



May 2016

VETERANS' HEALTH CARE

Proper Plan Needed to Modernize System for Paying Community Providers

GAO Highlights

Highlights of [GAO-16-353](#), a report to Congressional Committees

Why GAO Did This Study

Due to recent increases in utilization of VA care in the community, VHA has had difficulty processing claims in a timely manner.

Congress included a provision in law for GAO to review VHA's payment timeliness and to compare it to that of Medicare and TRICARE. This report examines, among other objectives, (1) VHA's, Medicare's, and TRICARE's claims processing timeliness; (2) factors that have impeded VHA's claims processing timeliness and community providers' experiences; and (3) VHA's recent actions and plans to improve its claims processing timeliness. GAO obtained fiscal year 2015 data on VHA's, Medicare's, and TRICARE's claims processing timeliness. GAO also visited 4 of 95 VHA claims processing locations (selected based on variation in geographic location, performance, and workload); reviewed VHA documents and 156 claims from the 4 locations; and interviewed officials from VHA, Medicare, TRICARE, and selected community providers and state hospital associations. Results from GAO's analysis cannot be generalized to all VHA claims processing locations or community providers.

What GAO Recommends

GAO recommends that VA develop a written plan for modernizing its claims processing system that includes a detailed schedule, costs, and performance measures. VA concurred with this recommendation and plans to address it through the planned consolidation of its VA care in the community programs.

View [GAO-16-353](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

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Proper Plan Needed to Modernize System for Paying Community Providers

What GAO Found

To help ensure that veterans are provided timely and accessible health care services, the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) has purchased care from non-VA community providers through its care in the community programs since as early as 1945. VHA's agency-wide data show that in fiscal year 2015, it processed about 66 percent of claims within the agency's required time frame of 30 days or less, whereas data from Medicare and TRICARE (the Department of Defense's health care system) show that their contractors processed about 99 percent of claims within 30 days or less. However, VHA's data likely overstate its performance because they do not account for delays in scanning paper claims, which officials say account for approximately 60 percent of claims. GAO's analysis of 156 claims from four VHA claims processing locations indicated that it took an average of 2 weeks for VHA staff to scan paper claims into VHA's claims processing system, and GAO observed multiple bins of paper claims that had been awaiting scanning at one site for over a month. In a 2014 report, GAO recommended that VHA take action to ensure that all of its claims processing locations comply with its policy of scanning claims into VHA's claims processing system upon receipt. While VHA agreed with this recommendation and attempted to reiterate the policy through various means, GAO's more recent findings suggest that VHA did not monitor the operational effectiveness of these corrective actions. VHA officials said that they have since begun requiring managers at their claims processing locations to periodically certify in writing that all incoming paper claims have been date-stamped and scanned on the day of receipt.

VHA officials and claims processing staff from the four locations GAO visited indicated that technology limitations, manual processes, and staffing shortages have delayed VHA's claims processing. For example, VHA's claims processing system lacks the capacity to automatically adjudicate claims. VHA staff instead must rely on manual processes, which they say delay payments to community providers. In addition, community providers and state hospital association respondents who participated in GAO's review said they had experienced various issues with VHA's claims processing system. For example, almost all providers described the administrative burden of submitting claims and related medical documentation to VHA and a lack of responsiveness from VHA's claims processing locations when the providers contacted them to follow up on claims.

While VHA has recently implemented interim measures to address challenges that have delayed claims processing—such as eliminating certain medical documentation requirements and filling staff vacancies—the agency does not expect to deploy solutions to address all challenges until fiscal year 2018 or later. VHA is currently examining options for modernizing its claims processing system but has not yet communicated to Congress or other external stakeholders a sound plan that clearly addresses the components identified in past GAO work (such as a detailed schedule, estimated costs, and measures of progress). This is concerning, given VA's past failed attempts to modernize key information technology systems. While the agency expects to significantly increase its reliance on community providers to deliver care to veterans in the future, it risks losing their cooperation if it does not improve its payment timeliness.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DHA	Defense Health Agency
DOD	Department of Defense
FBCS	Fee Basis Claims System
HHS	Department of Health and Human Services
MAC	Medicare Administrative Contractor
MCSC	managed care support contractor
PC3	Patient-Centered Community Care
TPA	third party administrator
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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May 11, 2016

The Honorable Johnny Isakson
Chairman
The Honorable Richard Blumenthal
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable Jeff Miller
Chairman
The Honorable Corrine Brown
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The majority of veterans utilizing health care services delivered by the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) receive care in VHA-operated medical facilities, such as VA medical centers or community-based outpatient clinics. However, some VA medical facilities have faced problems with long wait times for providing care to veterans, and others may be unable to provide certain specialty care services. To help ensure that veterans are provided timely and accessible care, the agency has purchased health care services from non-VA community providers through its care in the community programs since as early as 1945.¹ While the eligibility requirements and types of care purchased through the programs currently vary, in general VA purchases community care when (1) wait times for appointments at VA medical facilities exceed VA standards; (2) a VA medical facility is unable to provide certain specialty care services, such as cardiology or orthopedics; or (3) a veteran would have to travel long distances to obtain

¹For the purposes of this report, the terms "VA care in the community" and "community providers" refer, respectively, to the services the Department purchases outside VA medical facilities and the community providers who deliver the services under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153. Before 2015, VHA referred to "community providers" as "non-VA providers" or "fee basis providers" and to "VA care in the community" as "non-VA medical care" or "fee basis care." The agency began using the terms "community providers" and "VA care in the community" in the spring of 2015.

care at a VA medical facility. Under certain circumstances, VA is also authorized to reimburse community providers for emergency care they deliver to veterans.² When veterans obtain care from community providers, these providers submit claims to VA for reimbursement on a fee-for-service basis. VHA staff at 95 claims processing locations throughout the country are responsible for processing and paying these claims.³

VA's expenditures for its care in the community programs, the number of veterans for whom VA has purchased care, and the number of claims processed by VHA have all grown considerably in recent years. In fiscal year 2015, VA obligated about \$10.1 billion for care in the community for about 1.5 million veterans.⁴ Three years earlier, in fiscal year 2012, VA spent about \$4.5 billion on care in the community for about 983,000 veterans—about 50 percent fewer veterans than were served in fiscal year 2015. From fiscal year 2012 through fiscal year 2015, the number of processed claims for VA care in the community programs increased by about 81 percent.

The substantial increase in utilization of VA care in the community programs poses challenges for VHA, which has had ongoing difficulty processing claims from community providers in a timely manner. A 2010 report by the VA Office of the Inspector General found that VHA needed

²All emergency care purchased from community providers must meet the prudent layperson standard of an emergency, which means that the veteran's condition is of such a nature that a prudent layperson would reasonably expect that a delay in seeking immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b). There are additional criteria that must be met for VA to purchase emergency care from community providers, and these criteria vary depending on whether the care is related to the veteran's service-connected disability.

³As of November 2015, there were 141 VA medical facilities responsible for authorizing VA care in the community services and 95 VHA claims processing locations responsible for processing claims from community providers.

⁴Final figures for expenditures on VA care in the community in fiscal year 2015 will not be available until VHA's claims processing locations finish processing all fiscal year 2015 claims. As of October 29, 2015, VA had paid about \$6.65 billion for VA care in the community that was delivered in fiscal year 2015, but VHA's claims processing locations also had a backlog of about 453,000 claims awaiting processing as of that date. Total fiscal year 2015 expenditures for VA care in the community are expected to be closer to \$10.1 billion.

to take action to address the timeliness of its claims processing.⁵ In 2011, the National Academy for Public Administration described numerous weaknesses in VHA's claims processing system, which delayed payments to community providers.⁶ In 2014 and 2015, we reported that some providers delivering services through VA care in the community experienced lengthy delays (i.e., in some cases, months or years) receiving payment on their claims.⁷ During a June 3, 2015 hearing of the House Committee on Veterans' Affairs' Subcommittee on Health, several witnesses testified about VHA's continued lack of timeliness in paying claims for VA care in the community services. The VA Budget and Choice Improvement Act required VHA to develop a plan for consolidating its VA care in the community programs (of which there are currently about 10), and VHA submitted this plan to Congress on October 30, 2015.⁸ As part of this plan, VHA said it would examine potential strategies for improving the timeliness and accuracy of its payments to community providers.

The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) included a provision for us to report to Congress about the timeliness of VA's payments for claims submitted by community providers when veterans access care outside the VA health care system, and to compare the timeliness of VA's payments to community providers to the timeliness of payments providers receive from Medicare and TRICARE, the Department of Defense's (DOD) health care system.⁹ In February 2016,

⁵Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration: Audit of Non-VA Inpatient Fee Care Program*, 09-03408-227 (Washington, D.C.: Aug. 18, 2010).

⁶National Academy of Public Administration, *Veterans Health Administration Fee Care Program* (Washington, D.C.: Sept. 2011).

⁷See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, [GAO-14-175](#) (Washington, D.C.: March 6, 2014) and GAO, *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, [GAO-16-24](#) (Washington, D.C.: Oct. 28, 2015). A list of other related GAO products can be found at the end of this report.

⁸Pub. L. No. 114-41, Tit. IV, § 4002, 129 Stat. 443, 461 (2015).

⁹Pub. L. No. 113-146, § 105(c), 128 Stat. 1754, 1767 (2014). TRICARE is a regionally structured health care program for military service members, retirees, and their dependents and survivors. Under TRICARE, beneficiaries obtain health care either through DOD's direct care system of military hospitals and clinics (referred to as military treatment facilities), or they receive care through DOD's purchased care system of civilian providers and civilian facilities. In this report, we focus on the purchased care component of TRICARE.

we presented preliminary observations from this work at a hearing of the House Committee on Veterans' Affairs' Subcommittee on Health.¹⁰ This report examines:

1. similarities and differences between VHA's, Medicare's, and TRICARE's systems for processing health care claims;
2. how VHA's claims processing timeliness in fiscal year 2015 compared to Medicare's and TRICARE's, and whether these entities pay interest penalties on late payments;
3. the factors that have impeded the timeliness of VHA's claims processing and payment;
4. providers' experiences with VHA's claims processing; and
5. VHA's recent actions and plans to improve the timeliness of claims processing and payments for VA care in the community.

To describe the similarities and differences between VHA's, Medicare's, and TRICARE's systems for processing health care claims, we reviewed applicable policies and other documentation and interviewed officials from VHA; the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS) agency that administers Medicare; and the Defense Health Agency (DHA), the DOD agency that administers TRICARE. We also interviewed officials from the contractor that is responsible for processing all TRICARE claims and officials from 1 of the 16 contractors that are responsible for processing Medicare claims.¹¹

¹⁰See GAO, *Veterans' Health Care: Preliminary Observations on VHA's Claims Processing Delays and Efforts to Improve the Timeliness of Payments to Community Providers*, [GAO-16-380T](#) (Washington, D.C.: Feb. 11, 2016).

¹¹As of 2015, the Medicare contractor we interviewed was responsible for processing about 9 percent of all Part A and Part B Medicare claims and 50 percent of all fee-for-service Medicare home health and hospice claims. The Medicare program consists of four parts. Parts A and B are known as original Medicare or Medicare fee-for-service. Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health services, and hospice care. Part B services include physician and outpatient hospital services, diagnostic tests, mental health services, outpatient physical and occupational therapy, ambulance services, some home health services, prosthetics, orthotics, and supplies. Part C is the private health plan alternative to Medicare fee-for-service and primarily consists of plans that are offered under the Medicare Advantage Program. Part D is the outpatient prescription drug benefit, which is provided through private plans.

To examine how VHA's claims processing timeliness compared to Medicare's and TRICARE's, and whether these entities pay interest on late claims, we reviewed applicable policies, interviewed agency officials, and obtained fiscal year 2015 data on claims processing timeliness.¹² Agency officials reported to us the amounts that VHA, CMS, and DHA spent in fiscal year 2014 for interest penalties paid on late payments to providers. The claims processing timeliness data we obtained provided information on the percentage of paid and denied claims in fiscal year 2015 that met each agency's claims processing timeliness requirements. To assess the reliability of these data, we interviewed knowledgeable agency officials about their respective data sources and methods for collecting data. We found CMS's and DHA's data to be sufficiently reliable for reporting Medicare's and TRICARE's claims processing timeliness in fiscal year 2015. However, as we discuss in this report, we determined that VHA's timeliness data had limitations. As there were no other data available from VHA, we used these data for making comparisons to Medicare's and TRICARE's claims processing timeliness in fiscal year 2015, but we also note the limitations of VHA's data in making the comparisons.

To examine factors that have impeded the timeliness of VHA's claims processing and payment, we used VHA data on the timeliness of payments for claims that were processed between February 2014 and February 2015—the most recent data that were available when we began our study—to select a non-random sample of four VHA claims processing locations where we conducted site visits in May and June 2015.¹³ (See table 1.)

¹²From VHA, we interviewed officials from the Chief Business Office for Purchased Care; from CMS, we interviewed officials from the Medicare Contractor Management Group; and from DHA, we interviewed the Chief of TRICARE Contract Resource Management.

¹³The claims processing locations in our sample represented different regions in the United States, a range in timeliness performance, and a range in claims processing workload (i.e., the number of VA medical facilities for which the claims processing location processed claims).

Table 1: Veterans Health Administration (VHA) Claims Processing Locations GAO Visited

VHA claims processing location	Geographic location of the claims processing location	Number of VA medical facilities for which the location processes claims
St. Louis, MO	Midwest	1 VA medical facility in St. Louis, MO
Helena, MT	West	13 VA medical facilities located in Veterans Integrated Service Networks (VISN) 18 and 19 ^a
Columbia, SC	South	1 VA medical facility located in Columbia, SC
Pearl, MS	South	10 VA medical facilities located in VISN 16

Source: GAO | GAO-16-353

^aVHA's health care system is divided into areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA medical facilities that are within their boundaries. Each VA medical facility is assigned to a single VISN. At the start of fiscal year 2016, there were 21 VISNs, but VA is in the process of consolidating some networks so that by the end of fiscal year 2018, there will be 18 networks.

At each of these four sites, we interviewed managers and staff responsible for claims processing and reviewed documentation associated with a non-random sample of approximately 20 inpatient claims and 20 outpatient claims that were paid between February 2014 and February 2015.¹⁴ We reviewed documentation for 156 claims in all and interviewed managers or staff at the four VHA claims processing locations to identify factors affecting the timeliness of payments for these claims.¹⁵ To assess the reliability of VHA's data on claims that were paid between February 2014 and February 2015, we interviewed knowledgeable agency officials, manually reviewed the content of the claims data, and electronically tested the data for missing values, outliers, and obvious errors. We concluded that the data were sufficiently reliable

¹⁴We selected our claims sample on the basis of variation in the number of days elapsed between the date of service and the date of payment for each claim.

¹⁵We initially selected and received documentation for 40 claims—20 inpatient and 20 outpatient claims—from each of the four VHA claims processing locations we visited, for a total of 160 claims. However, we excluded 4 claims from our sample, resulting in a sample of 156 claims. We excluded 1 claim because the documentation we received was not for the claim we had originally selected as part of our sample, and we excluded 3 other claims because they were claims for home health services, which are processed using a different system than the one that is used to process other claims for VA care in the community.

for selecting the samples of VHA claims we reviewed. Because the claims processing locations and samples of claims we reviewed at each location were not selected to be representative, we cannot generalize our findings to all VHA claims processing locations or to all claims for VA care in the community programs.

To gather information about community providers' experiences with obtaining payments for their VA care in the community claims, we (1) interviewed officials from a non-random sample of 12 community providers that had submitted claims to the four VHA claims processing locations we visited and (2) collected written statements from 12 state hospital associations, which collectively represent the views of at least 117 different hospitals or health care systems.¹⁶ We selected the non-random sample of community providers we interviewed from among the providers that had submitted the most claims between February 2014 and February 2015 to the four VHA claims processing locations we visited. Because the community providers and state hospital associations that participated in our review were not selected to be representative, we cannot generalize our findings to all providers participating in VA care in the community programs.

To examine VHA's recent actions and plans to improve its claims processing and payment timeliness for VA care in the community, we reviewed relevant VA and VHA documentation and interviewed VHA officials. We also assessed VHA's plans in the context of (1) best practices for planning, as reported in our prior work and (2) federal

¹⁶To collect statements from the state hospital associations about their experiences with VHA's claims processing, we obtained the assistance of the American Hospital Association, which solicited written responses to our questions from its member hospitals and health care systems.

standards for internal control for information and communication.¹⁷ The internal control standard for information and communication relates to an agency's ability to internally and externally communicate the necessary quality information to achieve the entity's objectives.

We conducted this performance audit from January 2015 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Choice Act Provisions Related to Oversight of VA Care in the Community and Payment for Community Providers

In response to a provision of the Choice Act, on October 1, 2014, VA transferred funds and the responsibility for managing and overseeing the processing of claims for VA care in the community from its Veterans Integrated Service Networks (VISN) and VA medical centers to VHA's Chief Business Office for Purchased Care.¹⁸ Previously, VISNs and medical facilities were responsible for managing both their own budgets

¹⁷In past reports, we have identified best practices in planning. For example, see GAO, *Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism*, [GAO-04-408T](#) (Washington, D.C.: Feb. 3, 2004) and GAO, *Social Security Disability: Additional Performance Measures and Better Cost Estimates Could Help Improve SSA's Efforts to Eliminate Its Hearings Backlog*, [GAO-09-398](#) (Washington, D.C.: Sept. 9, 2009). To identify these best practices, we consulted numerous sources, including the Government Performance and Results Act of 1993, general literature on strategic planning and performance, and guidance from the Office of Management and Budget. Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 2014) and GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1999).

¹⁸Pub. L. No. 113-146, § 106, 128 Stat.1754, 1768-69 (2014). VHA's health care system is divided into areas called Veterans Integrated Service Networks (VISN), each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA medical facilities that are within their boundaries. Each VA medical facility is assigned to a single VISN. At the start of fiscal year 2016, there were 21 VISNs, but VA is in the process of consolidating some VISNs so that by the end of fiscal year 2018, there will be 18 VISNs.

for VA care in the community and the staff who processed these claims. After this transition, VHA's Chief Business Office for Purchased Care became responsible for overseeing VA's budget for care in the community programs and more than 2,000 staff working at 95 claims processing locations nationwide.

The Choice Act also expressed the sense of Congress that VA shall comply with the Prompt Payment Act's implementing regulations (or any corresponding similar regulation or ruling) when paying for health care pursuant to contracts entered into with community providers.¹⁹ Generally, these regulations require executive branch agencies to add interest penalties to payments made to vendors after the contractually established payment date, or 30 days after the date the agencies receive a proper invoice, if the contract specifies no due date.²⁰

Types of VA Care in the Community Services, Reimbursement Rates, and Medical Documentation Requirements

VHA has numerous programs through which it purchases VA care in the community services. As described in a recent independent assessment of VHA's health care system, which was mandated by the Choice Act, these programs offer different types of services, have varying eligibility criteria for veterans and community providers, and establish different rules governing payment rates.²¹ In addition, for all types of VA care in the community services except individually authorized outpatient care, community providers must include medical documentation with the claims they submit to VHA or its third party administrators (TPA). (See appendix I for a side-by-side comparison of various features of these VA care in the community programs.) In what follows we describe the primary ways VHA purchases care in the community services, the applicable payment rates,

¹⁹Id., § 105(a), 128 Stat. at 1767, referring to 5 C.F.R., part 1315, the regulations implementing the statutory provisions commonly referred to as the Prompt Payment Act, 31 U.S.C. §§ 3901-3907.

²⁰5 C.F.R. §§ 1315.1(a)-(b), 1315.4(g)(1) (2016).

²¹See CMS Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities) and Assessment I (Business Processes)* (Sept. 1, 2015).

and the extent to which VHA requires community providers to submit medical documentation as a condition of claims payment.²²

- **Individually authorized care.** The primary means by which VHA has traditionally purchased care from community providers is through individual authorizations. When a veteran cannot access a particular specialty care service from a VA medical facility—either because the service is not offered or the veteran would have to travel a long distance to obtain it from a VA medical facility—the veteran’s VA clinician may request an individual authorization for the veteran to obtain the service from a community provider. If this request is approved and the veteran is able to find a community provider who is willing to accept VA payment, VA will pay the provider on a fee-for-service basis. Generally, VA pays Medicare’s applicable rates for these services, unless the community provider has an existing contract and negotiated rates with a VA medical facility. For individually authorized inpatient care, VHA requires community providers to submit discharge summaries, at a minimum, as a condition of payment. For individually authorized outpatient care, the authorization itself states whether the community provider must submit any medical documentation as a condition of payment.
- **Emergency care.** When care in the community is not preauthorized, VA may reimburse community providers for two different types of emergency care: 1) emergency care for a condition related to a veteran’s service-connected disability and 2) emergency care for a condition not related to a veteran’s service-connected disability.²³ The latter care is commonly referred to as Millennium Act emergency care.²⁴

For service-connected emergency care, VA generally pays applicable Medicare rates, unless the community provider has an existing

²²In addition to the programs described here, VA is also authorized to purchase care from DOD and Indian Health Service facilities, community nursing homes, and community-based home health providers. 38 U.S.C. §§ 1710, 1720, 8111, and 8153.

²³See 38 U.S.C. § 1728(a)(1)-(4), which lists the circumstances under which VA may reimburse community providers for emergency care related to a service-connected disability. See 38 U.S.C. § 1725, which sets forth VA’s authority to reimburse community providers for emergency care not related to a service-connected disability.

²⁴See Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, § 111(a) 113 Stat.1545, 1553-55 (1999) (codified, as amended, at 38 U.S.C. § 1725).

contract and negotiated rates with a VA medical facility. For Millennium Act emergency care, VA generally pays the lesser of the amount for which the veteran is personally liable (if a third party such as motor vehicle insurance or workers' compensation insurance first paid for some portion of the care) or 70 percent of applicable Medicare rates. For claims for both types of emergency care, community providers are required to submit accompanying medical documentation, so that clinicians at VHA's claims processing locations can determine whether or not the condition treated is related to the veteran's service-connected disability and whether it meets the prudent layperson standard of an emergency.²⁵ (See appendix II for a more detailed description of the criteria that must be met before VHA will pay claims for these two types of emergency care.)

- **Patient-Centered Community Care (PC3).** In September 2013, VA awarded contracts to two TPAs to develop regional networks of community providers of specialty care, mental health care, limited emergency care, and maternity and limited newborn care when such care is not feasibly available from a VA medical facility. VA and the TPAs began implementing the PC3 program in October 2013, and it was fully implemented nationwide as of April 2014.²⁶ In August 2014, VA expanded the PC3 program to allow community providers of primary care to join the networks. PC3 is a program VA created under existing statutory authorities, not a program specifically enacted by law. To be eligible to obtain care from PC3 providers, veterans must meet the same criteria that are required for individually authorized VA care in the community services.

²⁵A medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b) (2015). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

²⁶The two TPAs that currently hold these contracts are TriWest Healthcare Alliance and Health Net Federal Services.

When they join the PC3 networks, community providers agree to be reimbursed at rates they negotiate with the TPAs, which are reportedly a percentage of applicable Medicare rates. As a condition of their contracts with VA, the two TPAs are required to collect medical documentation from the community providers and return it to VA in a timely manner. Upon receipt, staff at VA facilities are responsible for scanning the associated medical documentation and entering it into the veteran's VA electronic health record so that it is available for VA clinicians to view.

- **Veterans Choice Program.** The Choice Act provides, among other things, temporary authority and funding for veterans to obtain health care services from community providers to address long wait times, lengthy travel distances, or other challenges accessing care at a VA medical facility.²⁷ Under this authority, VHA introduced the Veterans Choice Program in November 2014. As stated in VA's December 2015 guidance, the program currently allows eligible veterans to obtain health care services from community providers if the veteran meets any of the following criteria:²⁸
 - the next available medical appointment with a VA provider is more than 30 days from the veteran's preferred date or the date the veteran's physician determines he or she should be seen;
 - the veteran lives more than 40 miles driving distance from the nearest VA facility with a full-time primary care physician;
 - the veteran needs to travel by air, boat, or ferry to the VA facility that is closest to his or her home;

²⁷Pub. L. No. 113-146, § 101, 128 Stat. 1754, 1755-1765 (2014).

²⁸Veterans Health Administration, *Veterans Choice Program Eligibility Details* (Washington, D.C.: U.S. Department of Veterans Affairs, 2015). In its technical comments on a draft of this report, VA officials suggested that our report should track the statutory language in describing Choice Act requirements. However, we chose to present the statutory summaries VA published in its guidance in order to reflect VA's implementation of applicable statutory requirements.

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- the veteran faces an unusual or excessive burden in traveling to a VA facility based on geographic challenges, environmental factors, or a medical condition;²⁹
 - the veteran’s specific health care needs, including the nature and frequency of care needed, warrants participation in the program;³⁰ or
 - the veteran lives in a state or territory without a full-service VA medical facility.³¹

To administer the Veterans Choice Program, VHA modified its contracts with the two TPAs it selected to administer the PC3 program. These contractors are responsible for enrolling community providers in their networks or establishing Choice Provider Agreements with the providers. Veterans Choice Program providers are generally paid Medicare rates.

VHA’s System for Processing Claims from Community Providers

Community providers who are not part of the PC3 or Veterans Choice Program networks submit claims for preauthorized and emergency care to one of VHA’s 95 claims processing locations.³² For PC3 and Veterans Choice Program care, community providers submit their claims to the TPAs, and the TPAs process the claims and pay the community providers. Subsequently, the TPAs submit claims to one of VHA’s claims processing locations—either the one that authorized the care, in the case of PC3 claims, or the one that VHA has designated to receive Veterans Choice Program claims. VHA staff at these locations process these

²⁹Staff at the veteran’s local VA medical facility will work with the veteran to determine if he or she meets this criterion.

³⁰A determination about whether the veteran meets this criterion will be made in conjunction with staff at the veteran’s local VA medical facility.

³¹Specifically, veterans who reside in Alaska, Hawaii, New Hampshire, or a U.S. territory would be eligible for the program under this criterion. Veterans residing in New Hampshire are only eligible if they reside more than 20 miles away from the White River Junction VA medical center, which is located in Vermont.

³²If the claim is for individually authorized care, the community provider submits it to the VHA claims processing location that processes claims for the VA medical facility that authorized the veteran’s care. If the claim is for emergency care, the community provider submits it to the VHA claims processing location that processes claims for the VA medical facility that is located nearest to where the community provider rendered the emergency services.

claims using the same systems used to process other claims for VA care in the community programs, and VA reimburses the TPAs for the care.

To process claims for VA care in the community programs, staff at VHA's claims processing locations use the Fee Basis Claims System (FBCS). FBCS does not automatically apply relevant criteria and determine whether claims are eligible for payment. Rather, staff at VHA's claims processing locations must make determinations about which payment authority applies to each claim and which claims meet applicable administrative and clinical criteria for payment. (See table 2 for a description of these steps.) In addition to processing claims for VA care in the community programs, staff at VHA's claims processing locations are also responsible for responding to telephone inquiries from community providers who call to check the status of their claims or inquire about claims that have been rejected.

Table 2: Veterans Health Administration's (VHA) Steps for Processing Claims for Care in the Community, as of March 2016

Processing step	Description
Receipt and scanning of claims and medical documentation	VHA policy requires that paper claims be manually date-stamped and scanned into the Fee Basis Claims System (FBCS) upon receipt. Electronic claims are imported into FBCS. If the community provider is required to submit medical documentation for the claim to be processed—which is the case for most types of the Department of Veterans Affairs' (VA) care in the community services—VA can only accept it in paper form, and the medical documentation must also be scanned into FBCS.
Verification	Once paper claims are scanned, staff at VHA's claims processing locations visually compare the scanned image of the claim to the text in FBCS to verify that the system accurately captured information from the claim and then manually enter any information that is missing or not accurately captured. They also determine whether claims should be rejected as duplicates of other claims that have already been processed.
Distribution	After electronic and paper claims are entered into FBCS, staff at the VHA claims processing location electronically route the claims to staff with the appropriate processing expertise.
Processing	Staff at VHA's claims processing locations use FBCS to review claims for VA care in the community and determine whether the claims meet administrative and clinical criteria for payment.
Approval or rejection	In FBCS, VHA's claims processing staff manually check off each line item that is approved for payment on a claim and enter into FBCS reasons for rejecting any items not approved for payment. After determining which line items should be paid, the staff use FBCS to calculate payment amounts for each approved line item.

Processing step	Description
Payment	After approving claims for payment, staff at VHA's claims processing locations route the claims to VA's "program integrity tool," which electronically checks claims for potential improper payments before any payments are made. Claims are then released for payment; VA's financial services center issues an electronic payment to the community provider or the third party administrator (TPA), and claims processing staff mark the claims as paid in FBCS.
Notification to community provider	After claims have been paid or rejected, FBCS generates preliminary fee remittance advice reports, which staff at VHA's claims processing locations must print and mail to the community providers and TPAs. These documents include a listing of claim dates and services, the reasons why payments for any services were rejected, and the payment amounts for approved services.

Source: GAO analysis of VHA documents. | GAO-16-353

For an illustration of the steps VHA staff must take to process claims from community providers and the TPAs, including which steps require manual intervention from staff, see appendix III.

VHA, Medicare, and TRICARE Claims Processing Timeliness Requirements

VHA, CMS, and DHA all have requirements for claims processing timeliness. See table 3.

Table 3: Agencies' Claims Processing Timeliness Requirements

Agency	Requirement
Veterans Health Administration (VHA)	A VHA directive states that 90 percent of all claims for the Department of Veterans Affairs' (VA) care in the community services must be processed (either paid or rejected) within 30 days of receipt. ^a
Centers for Medicare & Medicaid Services (CMS)	For Medicare claims, the standards were set by law and require that 95 percent of clean claims—those claims with sufficient information to be processed (either paid or denied)—must be processed within 30 days of receipt. ^b In accordance with statute, CMS's manual for processing Medicare claims states that the remaining claims must be processed within 45 days of receipt. ^c
Defense Health Agency (DHA)	TRICARE Managed Care Support Contractors are subject to claims processing timeliness requirements outlined in law and in DHA's TRICARE Operations Manual. The requirements in the Operations Manual are more stringent than in the law. The manual states that 98 percent of claims with sufficient information to be processed must be paid or denied within 30 days of receipt and that all claims must be processed to completion within 90 days of receipt. ^d

Source: GAO analysis of VHA, CMS, and DHA policies. | GAO-16-353

^aVHA Directive 2010-005, Timeliness Standards for Processing Non-VA Provider Claims (Jan. 27, 2010).

^bA "clean claim" has no defect or impropriety (including a lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. 42 U.S.C. § 1395h(c)(2)(B). Other claims require additional investigation or development before they can be paid. CMS, Medicare Claims Processing Manual, Publication 100-04 (Baltimore, MD: May 15, 2015).

^c42 U.S.C. § 1395ff(a)(2).

^dBy law, 95 percent of clean TRICARE claims must be processed within 30 days of submission to the claims processor, and all clean claims must be processed within 100 days of submission to the claims processor. 10 U.S.C. § 1095c(a).

While Steps for Processing Claims are Similar, VHA's Claims Processing System Is Considerably Less Automated than Medicare's and TRICARE's Systems

VHA, Medicare, and TRICARE follow similar steps to process claims for care they purchase on behalf of their beneficiaries. For example—even though paper claims account for a relatively small proportion of the overall number of claims submitted by Medicare and TRICARE providers—Medicare's and TRICARE's claims processors must scan incoming paper claims and verify that information from the claims was captured accurately when the claims were scanned, just as staff at VHA's claims processing locations must do. In addition, like VHA, Medicare's and TRICARE's claims processors send notifications to providers after claims have been processed, to inform them of whether payments were approved or denied for each service listed on the claim.

Even though these three agencies follow similar steps to process claims, the volume of claims that the agencies process varies widely, and the actual systems they use to carry out these steps differ markedly in several key respects.³³ (For a summary of selected similarities and differences between VHA's, Medicare's, and TRICARE's systems for processing health care claims, see appendix IV.) Based on our review of applicable documentation and interviews with officials from CMS, DHA, and two contractors that process Medicare and TRICARE claims, we identified the following key differences between VHA's claims processing system and those of Medicare and TRICARE.³⁴ These key differences are described below.

- **Use of contractors.** Unlike VHA, which employs its own staff to process claims for VA care in the community services, both Medicare

³³In fiscal year 2014, VHA processed about 13.3 million claims, Medicare Administrative Contractors (MAC) processed over 1.2 billion claims, and TRICARE contractors processed over 55.7 million claims.

³⁴In addition to the differences we describe between VHA's claims processing system and those of Medicare and TRICARE, it is also important to note that there are differences in the number of beneficiaries served by these three programs and the amounts they spend to purchase health care services. In addition, as we have described previously in this report, the eligibility criteria and payment amounts for each type of VA care in the community vary (for example, depending on whether the veteran has a service-connected disability and whether care was authorized in advance), whereas for Medicare and TRICARE, eligibility criteria and payment rates are more standardized.

and TRICARE use contractors to process claims for care purchased from community providers. CMS uses contractors called Medicare Administrative Contractors (MAC) to process claims for health care items and services. For TRICARE, DHA contracts with three managed care support contractors (MCSC), which are responsible for establishing regional networks of civilian providers, managing referrals, and providing customer service, among other things. To pay claims submitted by TRICARE's network providers, the three MCSCs have each subcontracted with a single claims processing contractor.³⁵

- **Number of claims processing locations.** Contractors responsible for processing Medicare and TRICARE claims operate in fewer locations than do staff at VHA's claims processing locations. Most Medicare Part A and Part B claims are processed by one of 12 jurisdiction-based MACs or 4 MACs that specialize in processing durable medical equipment claims, and all TRICARE claims are processed by a single contractor.³⁶ In contrast, VHA employed claims processing staff in 95 different locations as of November 2015, and community providers in a given state may submit claims to multiple VHA claims processing locations depending on the type of VA care in the community and where they render services. As we have reported previously, CMS established its current regional model for MACs in 2006 to improve services to beneficiaries and providers and achieve operational efficiencies and cost savings by better balancing claims processing workloads among fewer contractors than it had used in the past.³⁷ Prior to that time, there were 51 contractors responsible for processing Medicare claims.
- **Rate of electronic claim submission and the capacity to accept medical documentation electronically.** While VHA's, Medicare's, and TRICARE's claims processing systems can all accept claims submitted by providers electronically, the rate of electronic submission

³⁵According to DHA officials, DHA does not require the three MCSCs to contract with the same entity for claims processing; however, all three MCSCs have selected the same contractor to perform this function.

³⁶Some MACs have more than one contract. CMS reported that it had a total of nine contractors as of March 2016.

³⁷See GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, [GAO-10-71](#) (Washington, D.C.: Mar. 25, 2010).

is much higher in Medicare and TRICARE. According to CMS and DHA officials, the vast majority of Medicare and TRICARE claims are submitted electronically. The officials said that providers submit about 99 percent of Medicare Part A claims, 98 percent of Medicare Part B claims, and between 91 and 95 percent of TRICARE claims electronically. In contrast, according to VHA officials, about 40 percent of claims from providers participating in VA care in the community are submitted electronically. In addition, Medicare and TRICARE contractors' systems can accept medical documentation electronically, unlike VHA's claims processing system. VHA's inability to accept medical documentation electronically discourages community providers from submitting claims electronically because VHA cannot process many types of VA care in the community claims until medical documentation is received. Given the high rates of electronic submission of claims and medical documentation among Medicare and TRICARE providers, the Medicare and TRICARE contractors do not need to devote as many staff resources to scanning paper claims and medical documentation and verifying that information was captured accurately as do VHA's claims processing locations.

- **Prior authorization.** Unless services delivered by community providers meet the coverage criteria for one of VHA's two emergency care programs, all VA care in the community services must be authorized in advance of when veterans access the care in order for claims to be paid. Medicare, on the other hand, generally does not require prior authorization for the services it covers, and TRICARE generally only requires prior authorization for specialty care services.³⁸
- **Automatic claim adjudication.** Compared to VHA's system, the claims processing systems used in Medicare and TRICARE are more automated. While staff at VHA's claims processing locations must manually apply administrative and clinical criteria to every claim to determine whether the claims should be paid, officials from the Medicare and TRICARE contractors we interviewed described their organizations' high degrees of automatic claim adjudication. Medicare officials estimated that the MACs process about 95 percent of claims

³⁸In selected states, CMS is currently testing prior authorization for certain equipment and services, such as power mobility devices, hyperbaric oxygen therapy, and scheduled ambulance transport.

with no manual intervention, while officials from the contractor responsible for processing TRICARE claims estimated that their organization has automated about 75 percent of the claims adjudication process.

- **Medical documentation as a condition of payment.** While VHA requires providers to submit medical documentation for most types of claims for VA care in the community services, Medicare and TRICARE do not. According to CMS and DHA officials, Medicare and TRICARE providers are only required to submit medical documentation for a small percentage of claims, such as those flagged during a prepayment review for an examination of medical necessity.
- **Web-based provider self-service portals.** Unlike VHA, Medicare and TRICARE contractors both offer Web-based provider self-service portals. Officials from both of the Medicare and TRICARE contractors we interviewed said that their organizations had established Web-based provider self-service portals, which officials told us have decreased providers' reliance on telephone-based customer service. With these portals, providers are able to access information about the status of their claims 24 hours a day, 7 days a week. In contrast, VHA's claims processing locations only offer telephone-based provider customer service.
- **Dedicated customer service staff.** Unlike VHA, Medicare and TRICARE have dedicated customer service staff. The two Medicare and TRICARE contractors each maintain units with dedicated customer service staff, while staff in other units focus on claims processing. Officials from the two contractors said that within their customer service units, certain individuals are designated to handle calls from providers with more specialized, complex inquiries, while others focus on calls from providers who are inquiring about more routine issues. In contrast, at VHA's claims processing locations, staff who process claims are also responsible for delivering telephone-based provider customer service.

VHA's Fiscal Year
2015 Claims
Processing Was
Significantly Less
Timely Than
Medicare's and
TRICARE's, and VHA
Has Generally Not
Paid Interest
Penalties on Late
Payments

VHA's Claims Processing
and Payments Were
Significantly Less Timely
Than Medicare's and
TRICARE's in Fiscal Year
2015, and VHA's Data
Likely Overstate VHA's
Performance

In fiscal year 2015, VHA's processing of claims for VA care in the community services was significantly less timely than Medicare's and TRICARE's claims processing. VHA officials told us that the agency's fiscal year 2015 data show that VHA processed about 66 percent of claims within the agency's required timeframe of 30 days or less.³⁹ In contrast, CMS and DHA data show that in fiscal year 2015, Medicare's and TRICARE's claims processing contractors processed about 99 percent of claims within 30 or fewer days of receipt.⁴⁰ According to CMS

³⁹VHA's claims processing timeliness data do not account for the time it takes the TPAs to pay the community providers' PC3 or Veterans' Choice Program claims; however, VHA's data do account for the time it takes VHA's claims processing locations to process and reimburse the TPAs for these claims.

⁴⁰The percentages reported here are for VHA, Medicare, and TRICARE claims that were processed within 30 days of receipt when they had sufficient information to be processed. Both Medicare and TRICARE have separate measures of claims processing timeliness for claims that require additional information to be processed. VHA has only one measure of claims processing timeliness, but if additional information is needed to process claims after they are initially received, VHA excludes from its calculation of timeliness any calendar days that elapse while it is awaiting this information.

and DHA officials, the vast majority of Medicare and TRICARE claims are submitted electronically.⁴¹

However, the difference between VHA's claims processing timeliness and that of Medicare and TRICARE is likely greater than what VHA's available data indicate. Specifically, VHA's data likely overstate the agency's claims processing timeliness because they do not account for delays in scanning paper claims, and VHA officials told us that paper claims account for approximately 60 percent of claims for VA care in the community services. VHA's policy states that determinations of claims processing timeliness should be based upon the date the claim is received, but VHA's systems can only calculate timeliness on the basis of the date the claim is entered into FBCS.⁴² When community providers submit paper claims, VHA policy requires claims processing staff to manually date-stamp them and scan the paper claims into FBCS on the date of receipt.⁴³ Because FBCS cannot electronically read the dates that are manually stamped on paper claims, the scan date becomes the date used to calculate claims processing timeliness. To the extent that paper claims are not scanned into FBCS upon receipt, this elapsed time is not reflected in VHA's timeliness calculations.

⁴¹Officials from CMS and DHA told us that their data on claims processing timeliness are reliable because the majority of Medicare and TRICARE claims are submitted electronically, their contractors' claims processing systems are highly automated, and agency officials can independently validate the contractors' performance data.

⁴²VHA officials told us that they intend to revise their current policy for claims processing timeliness because it does not account for the fact that it takes more time, on average, for VHA to process emergency care claims than it does to process claims for preauthorized VA care in the community services. According to VHA officials, in fiscal year 2015, staff at their claims processing locations took an average of 32 days to process claims for emergency care, compared to an average of 16 days for claims for care that was preauthorized. VHA officials said future VHA policy would require claims for preauthorized care to be processed in 30 days or less and claims for emergency care be processed in 45 days or less, and that these new metrics would be more closely aligned with Medicare's and TRICARE's standards, which permit more time for claims processing when additional information must be requested from providers. However, VHA's systems will still measure claims processing timeliness on the basis of the dates claims are entered into FBCS, which may not be the actual date of receipt for paper claims, so it is unlikely that VHA's new metrics will result in more reliable estimates of the agency's claims processing timeliness.

⁴³In contrast, electronic claims automatically receive an electronic date-stamp when they are imported into FBCS.

Our review raises questions about whether staff at VHA's claims processing locations are following the agency's policy for scanning paper claims into FBCS upon receipt. We do not know the extent of delays in scanning paper claims at all of VHA's claims processing locations. However, our analysis of the non-generalizable sample of 156 claims for VA care in the community services from the four VHA claims processing locations we visited suggests that it may have taken about 2 weeks, on average, for staff to scan the paper claims in our sample into FBCS. This estimate is based on the number of days that elapsed between the dates that community providers created 86 of the 94 paper claims in our sample and the dates the claims were scanned into FBCS.⁴⁴ Based on this analysis, we found that the number of days between the creation date and the scanned date for the paper claims in our sample ranged from 2 days to 90 days.

Our observations at one claims processing location we visited were consistent with our analysis of the sampled claims. For example, we observed about a dozen bins of paper claims and medical documentation waiting to be scanned, and some of these bins were labeled with dates indicating they were received by the claims processing location about a month before our visit. Additionally, this claims processing location was the only one of the four claims processing locations we visited that manually date-stamped all of its paper claims upon receipt. Staff at another claims processing location told us that they only date-stamp paper claims for emergency care upon receipt because these claims are only eligible for payment if they have been received within a certain amount of time after the date of service.⁴⁵ However, the staff said they do

⁴⁴VHA policy states that when the date of receipt is unknown, VHA will use the date of the invoice to measure timeliness. Consistent with that policy, our estimate of the 2-week delay in scanning paper claims also factored in 2 days for the paper claims to be mailed to VHA by the community providers. Our analysis also excluded eight paper claims that appeared to be duplicates of claims that the community providers had previously submitted, based on the number of calendar days that had elapsed between the creation dates and the scan dates. At least one community provider told us that they do not change the creation date when they reprint and resubmit claims that VA has previously rejected.

⁴⁵Claims for Millennium Act emergency care must be received by VHA within 90 days of the latest of the following: the date of discharge; the date of the patient's death, provided death occurred during transport to or stay in an emergency treatment facility; or the date that the veteran exhausted, without success, actions to obtain payment or reimbursement from a third party. VHA can deny these emergency care claims if they are submitted by community providers after 90 days. Claims for emergency care related to a veteran's service-connected disability must be received within 2 years.

not date-stamp non-emergency care claims because to do so would be too time-consuming. Staff at the other two claims processing locations told us that they did not date-stamp any claims.

These findings from the four claims processing locations we visited for this review are consistent with the claims processing deficiencies we identified in our 2014 report on the implementation of the Millennium Act emergency care benefit.⁴⁶ Specifically, we found that the VHA claims processing locations we reviewed for the 2014 report were rarely date-stamping incoming paper claims and were not promptly scanning a significant percentage of the paper claims we reviewed into FBCS. In our report, we recommended that VHA implement measures to ensure that all incoming claims are date-stamped and scanned into FBCS on the date of receipt, and VA agreed with our recommendations. Soon after we issued our 2014 report, VHA reiterated its date-stamping and scanning policies on national calls with managers responsible for claims processing, posted articles in its biweekly bulletin for managers and staff, and conducted online training for staff that communicated the importance of date-stamping and promptly scanning claims. However, the observations from our most recent review of a new sample of claims at four other claims processing locations suggest that VHA had not monitored the operational effectiveness of their corrective actions to address our recommendation. VHA officials said that when they became aware of our more recent findings, they began requiring managers at their claims processing locations to periodically certify in writing that all incoming paper claims have been date-stamped and scanned on the day of receipt.

Unlike Medicare and TRICARE, VHA Has Historically Not Paid Interest Penalties on Most Late Payments to Community Providers but Recently Changed This Policy

Prior to October 2015, VHA did not pay interest penalties on most late payments to community providers, while Medicare and TRICARE have done so. Specifically, until October 2015, VHA paid no interest on claims it paid late for community care delivered by non-contract providers through individual authorizations. According to VHA officials, the agency had not paid interest penalties on these individually authorized services because VA did not interpret the Prompt Payment Act as applying to these payments. However, in October 2015, VA's Office of General Counsel issued a new legal opinion specifying that the Prompt Payment Act does apply to claims for VA care in the community services that were

⁴⁶See [GAO-14-175](#).

(1) individually authorized in advance, or (2) delivered by community providers who have contracted with the TPAs to participate in Veterans Choice Program networks.⁴⁷ Since then, from October 2, 2015 through November 21, 2015, VHA paid approximately \$409,000 in interest penalties on claims for this care, according to VHA officials.

To facilitate interest penalty payments on claims for individually authorized VA care in the community services, VHA established a process to automatically pay the penalties when these claims are paid more than 30 days after receipt. However, as we noted earlier in this report, paper claims that officially meet VHA's timeliness standard could have been in VHA's possession weeks before being scanned into FCBS, so VHA may not be paying interest on all claims that are paid more than 30 days after the claims were actually received. This issue will likely persist until VHA ensures that all incoming paper claims are date-stamped and scanned into FCBS on the date of receipt, as we recommended in 2014.

While VHA has not historically paid interest penalties on claims that are paid late, Medicare and TRICARE officials said their agencies have for many years considered the care provided under their programs to be subject to the Prompt Payment Act. In fiscal year 2014, CMS reported it paid about \$3.3 million in interest penalties to Medicare providers (with overall payments for fee-for-service Medicare services totaling \$357.3 billion), and DHA reported it paid about \$386,000 in interest penalties to TRICARE providers (with overall payments for TRICARE services totaling about \$10.5 billion).⁴⁸ For both Medicare and TRICARE, the sum of interest penalties—relative to overall expenditures for services—was relatively low in fiscal year 2014 because these programs generally paid providers in a timely manner. See table 4.

⁴⁷The decision also specified that the Prompt Payment Act does not apply to care authorized by the Choice Act pursuant to interagency or provider agreements.

⁴⁸The MACs only process Medicare fee-for-service claims, so the amounts of interest penalties and overall payments for Medicare services listed here do not include spending for claims or interest penalties paid by Medicare Part C (Medicare Advantage) and Medicare Part D (Medicare's outpatient prescription drug benefit).

Table 4: Reported Expenditures for the Department of Veterans Affairs' (VA) Care in the Community Services, Medicare, and TRICARE and Sum of Interest Penalties Paid on Late Payments in Fiscal Year 2014

Expenditures and Interest Penalties	VA care in the community	Medicare	TRICARE
Overall expenditures for care, fiscal year 2014	\$5.6 billion	\$357.3 billion ^a	\$10.5 billion
Sum of payments that were subject to the Prompt Payment Act, fiscal year 2014	\$1.7 billion	\$357.3 billion	\$10.5 billion
Sum of interest penalties on late payments for care, fiscal year 2014	\$290,000	\$3.3 million	\$386,000

Source: Veterans Health Administration, Centers for Medicare & Medicaid Services, and Defense Health Agency. | GAO-16-353

^aThis includes only payments for Medicare fee-for-service claims and excludes payments for Medicare Advantage (the private health plan alternative to Medicare fee-for-service) and Medicare Part D (the outpatient prescription drug benefit provided through private plans).

Technology Limitations and Related Staffing Challenges Have Delayed VHA's Claims Processing

During the course of our work, VHA officials and staff at three of the four claims processing locations we visited told us that the limitations of the existing information technology systems VHA uses for claims processing—and related workload challenges—have delayed processing and payment of claims for VA care in the community services. These identified limitations are described in more detail below.

- VHA cannot accept medical documentation electronically.** While VHA has the capacity to accept claims from community providers and the TPAs electronically, it does not have the capacity to accept medical documentation electronically from the providers and TPAs.⁴⁹ As a result, this documentation must be scanned into FBCS, which delays claims processing, according to VHA staff. Although VHA policy requires VHA staff to promptly scan paper claims into FBCS when received, delays can occur because staff do not have time to scan the high volume of claims and medical documentation received each day, and the capacity of scanning equipment is limited. For example, VHA staff at one claims processing location we visited told us that on Mondays (their heaviest day for mail since they do not

⁴⁹For all types of VA care in the community services except individually authorized outpatient care, community providers must include medical documentation with the claims they submit to VHA or the TPAs. According to VHA officials, VHA cannot accept any medical documentation electronically because of (1) a lack of interoperability between VHA's systems and the providers' and TPAs' systems and (2) concerns about safeguarding the security of veterans' health information, among other things. However, according to VHA officials, selected claims processing locations have made arrangements with certain community providers that enable VHA's claims processing staff to remotely access the community providers' medical records electronically.

receive mail on weekends), they do not scan any incoming claims with accompanying medical documentation. Instead, they generally scan only claims that do not have accompanying medical documentation on Mondays and then scan claims with accompanying medical documentation into FBCS on Tuesdays and Wednesdays. In some cases, the medical documentation community providers must submit can be extensive, which may further delay its entry into FBCS. Officials from one community health care system told us that the medical documentation they submit with claims can be between 25 to 75 pages for each patient. With most types of claims requiring medical documentation, staff at VHA's claims processing locations may need to scan a significant number of pages of incoming medical documentation each day.

- **Authorizations for VA care in the community services are not always readily available in FBCS.** Staff at three of the four VHA claims processing locations we visited told us that processing and payment can also be delayed when authorizations for VA care in the community services are unavailable in FBCS. Before a veteran obtains services from a community provider, staff at a VA medical facility must indicate in the veteran's VA electronic health record (a system separate from FBCS) that the services have been authorized, and then these staff must manually create an authorization in FBCS. However, VHA officials and staff told us that these authorizations are sometimes unavailable in FBCS at the time claims are processed, which delays processing and payment. The authorizations are unavailable because either (1) they have been electronically suspended in FBCS, and as a result staff at the VA medical facility that authorized the care must release them before any associated claims can be paid, or (2) the estimated date of service on the authorization does not match the date that services were actually

rendered, and new authorizations must be entered by staff at the authorizing VA medical facility before the claims can be paid.⁵⁰

In our non-generalizable sample of 156 claims, 25 claims were delayed in being processed because an authorization was not initially available in FBCS, resulting in an average delay of approximately 42 days in claims processing. Additionally, 8 of the 12 community providers we interviewed said they were aware that some of their payments had been delayed because authorizations were not available in FBCS when their claims arrived at the VHA claims processing location.

- **FBCS cannot automatically adjudicate claims.** FBCS cannot automatically adjudicate claims, and as a result, VHA staff must do so manually, which VHA staff told us can slow claims processing, make errors more likely, and delay claims payment. After information from claims and supporting medical documentation has been scanned and entered into FBCS, the system cannot fully adjudicate the claims without manual intervention. For example, FBCS lacks the capability to electronically apply relevant administrative and clinical criteria for Millennium Act emergency care claims, such as automatically determining whether a veteran is enrolled in the VHA health care system and whether they had received services from a VA clinician in the 24 months prior to accessing the emergency care. Instead, staff processing these claims perform searches within FBCS and manually select rejection reasons for any claims that do not meet VHA's administrative or clinical criteria for payment.

⁵⁰A VA official provided additional detail on why the authorizations may be electronically suspended in FBCS and why the dates of service on the authorization and claim may not match. According to this official, when authorizations for inpatient care in the community services are entered into FBCS, they must include a discharge date. Because this date is generally not known until after the claim is received, staff at VA medical facilities may electronically suspend the authorization until they are alerted by staff from the VHA claims processing location that the claim has been received. No claims can be paid against an authorization while it is suspended, causing it to seem as though it is not available in FBCS. In cases where authorizations are not suspended, estimated discharge dates are entered. If VHA receives any claims with dates of service occurring after the date that was originally estimated for that inpatient episode of care, staff at the VA medical facility must create new authorizations in FBCS before staff at the VHA claims processing location can pay the claims.

Among the 156 claims we reviewed at four claims processing locations, it took an average of 47 days for claims processing staff to determine that the claims met the administrative and clinical criteria for payment. In addition, even after claims are approved for payment, they require additional manual intervention before the community providers can be paid. For example, in cases where FBCS cannot automatically determine correct payment rates for VA care in the community services, VHA staff manually calculate VHA's payment rates and enter this information into FBCS. Staff we interviewed also told us that it usually takes about 2 days for claims to return from VA's program integrity tool, which is a system outside FBCS where claims are routed for prepayment review of potential improper payments. If corrections must be made after the claims return from this prepayment review, payments can be delayed further.

- **Weaknesses in FBCS and VHA's financial management systems have also delayed claims payments.** According to staff at three of the four claims processing locations we visited, payments on some VA care in the community claims are delayed because FBCS and VHA's financial management systems do not permit officials to efficiently monitor the availability of funds for VA care in the community services. To centralize its oversight of VA care in the community, the Choice Act directed VA to transfer the authority for processing payments for VA care in the community from its VISNs and VA medical centers to VHA's Chief Business Office for Purchased Care, a change VA implemented in October 2014. However, according to VHA officials from that office, monitoring the use of funds—at a national level—has remained largely a manual process due to limitations of FBCS and the use of separate systems to track obligations and expenditures. According to VHA officials, VHA uses historical data from FBCS to estimate obligations in VHA's financial management systems on a monthly basis, and these estimates have been unreasonably low for some services, given the unexpected increase in utilization of VA care in the community services over the course of fiscal year 2015. In addition, these officials said that FBCS does not fully interface with VHA's financial management systems used to track the availability of funds, which results in staff having to manually record the obligations for outpatient VA care in the community services in these systems on a monthly basis. Together, these two issues have impeded the ability of VHA to ensure that funds are available to pay claims for VA care in the community as they are approved, according to VHA officials responsible for monitoring the use of funds. We found that payments for 5 of the 156 claims we

reviewed from four claims processing locations were delayed because of these issues, resulting in payment delays that ranged from 1 to 215 days.⁵¹

- **Inadequate equipment delays scanning of both paper claims and medical documentation.** VHA officials also told us that inadequate scanning equipment delayed claims processing and adversely affected VHA's claims payment timeliness. At the time of our review, staff responsible for scanning paper claims and medical documentation at one of the four claims processing locations we visited told us that they did not have adequate scanning equipment. At this location, the scanners that staff showed us were small enough to be placed on desktops, while the trays for feeding documents into the scanners could only handle a limited number of pages at one time. With an estimated 60 percent of claims and 100 percent of medical documentation requiring scanning, these staff said that they struggled to keep up with the volume of paper coming in to their claims processing location.
- **Staffing shortages adversely affect claims processing timeliness.** In addition to the technological issues described above, VHA officials and staff also told us that staffing shortages have adversely affected VHA's claims processing timeliness. According to VHA officials, the overall number of authorized positions for claims processing staff did not change after the October 2014 organizational realignment that transferred claims processing management and oversight responsibilities to the Chief Business Office for Purchased Care. However, VHA officials said that VHA's claims processing workload increased considerably over the course of fiscal years 2014 and 2015. (See figure 1 for an illustration of the increase in VHA's claims processing workload from fiscal year 2012 through fiscal year 2015.)

⁵¹For more information on how VA tracks its obligations and projects utilization for care in the community programs, see GAO, *VA's Health Care Budget: Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization*, [GAO-16-374T](#) (Washington, D.C.: Feb. 10, 2016). This statement sets forth GAO's preliminary observations on actions VA is taking to better track obligations and project future budgetary needs, which will be addressed in a forthcoming report.

Figure 1: Number of Claims for VA Care in the Community Processed by the Veterans Health Administration (VHA), Fiscal Years 2012 – 2015



Source: VHA (data); GAO (illustration). | GAO-16-353

According to VHA officials and staff, the increase in workload contributed to poor staff morale, attrition, and staff shortages—all of which contributed to delays in processing and impeded VHA’s claims processing timeliness. VHA officials told us that in early fiscal year 2015, there were about 300 vacancies among the estimated 2,000 authorized positions for claims processing staff.

VA Care in the Community Providers Cite Administrative Burden, Lack of Notification, and Problems with Poor Customer Service

The 12 community providers and 12 state hospital association respondents who participated in our review told us about various issues they had experienced with VHA’s claims processing system. These issues are described in more detail below.

- Administrative burden of submitting claims and medical documentation to VHA.** Almost all of the community providers we interviewed (11 out of 12) and all of the state hospital association respondents that participated in our review described the administrative burden of submitting claims and medical documentation to their respective VHA claims processing locations. For example, one community provider told us that VHA claims only accounted for about five percent of their business, but the provider told us it employed one full-time staff member who was dedicated to

submitting claims to VHA and following up on unpaid ones. This same provider employed a second full-time staff member to handle Medicaid claims, but these accounted for about 85 percent of the provider's business.

According to many of the community providers that participated in our review, obtaining payment from VHA often requires repeated submission of claims and medical documentation. Officials from one community provider we interviewed said that at one point, they had been hand delivering paper medical documentation with paper copies of the related claims to their VHA claims processing location, but VHA staff at this location still routinely rejected their claims for a lack of medical documentation. Similarly, six state hospital association respondents also reported that their members' claims were often rejected, even though they always sent medical documentation to their VHA claims processing location by certified mail. Some of the community health care system and hospital officials who participated in our review explained that they often must submit medical documentation to their VHA claims processing location twice—once for the claim related to hospital services and again for claims related to physician services.

- **Lack of notification about claims decisions.** Community providers who participated in our review also explained that they rarely received written notifications from VHA about claims decisions. To inform community providers and the TPAs about whether their claims have been approved or rejected, staff at VHA's claims processing locations print notices, known as preliminary fee remittance advice reports, and mail them to the providers and TPAs.⁵² However, community providers who participated in our study stated that they rarely received these paper reports in the mail, and even though they received VA payments electronically, it was not clear without the remittance advice reports which claims the payments applied to or whether VHA denied payment for certain line items on some claims. Unlike Medicare and TRICARE, VHA has no online portal where community providers can electronically check the status of their claims to find out if the claims are awaiting processing or if VHA needs additional information to

⁵²The preliminary fee remittance advice reports include a listing of claim dates and services, the reasons why payments for any services were disapproved, and payment amounts for services that were approved.

process them. Several of the community providers who participated in our study told us that they would appreciate VHA establishing such a portal.

- **Issues with telephone-based provider customer service.** Almost all of the community providers and state hospital associations that participated in our review (9 out of 12 providers and 11 out of 12 associations) experienced issues with the telephone-based provider customer service at VHA's claims processing locations. For example,
 - officials from three of the community providers we interviewed reported that they routinely wait on hold for an hour or more while trying to follow up on unpaid claims.
 - Officials from a community health care system that operates 46 hospitals and submits claims to 5 different VHA claims processing locations said that 3 of these locations will not accept any phone calls and instead require providers to fax any questions about claim status.
 - According to officials from another community health care system, their VHA claims processing location has limited them to inquiring about only three claims per VHA staff member, per day. The officials explained that if they call twice on the same day and reach the same individual who has already checked the status of three claims, that person will refuse to check the status of additional claims; however, if they connect with a different VHA staff member, they may be able to inquire about additional claims.⁵³

⁵³VHA officials said that once they became aware of this practice in the summer of 2015, they contacted managers at their claims processing locations to advise them that they should not be limiting the number of claims each community provider could call and inquire about each day.

While VHA Has Implemented Interim Measures, the Agency Does Not Expect to Address All Claims Processing Challenges until Fiscal Year 2018 or Later

VHA Has Recently Eliminated Certain Medical Documentation Requirements, Filled Staff Vacancies, and Taken Other Steps to Improve Claims Processing Timeliness

In the course of our work, VHA officials reported that they implemented several measures in fiscal year 2015 and early fiscal year 2016 that were intended to improve the timeliness of VHA's payments to community providers and the TPAs. The following are the key steps that VHA officials have reported taking.

- **Elimination of certain medical documentation requirements.** On March 1, 2016, VA announced that it had modified its contracts with the TPAs so that community providers participating in the Choice Program will no longer be required to submit medical documentation before their VA care in the community claims can be paid. VA expects this will expedite the processing of claims from Choice Program providers. VHA's data indicate that the number of VA care in the community authorizations routed to the Choice Program first exceeded the number of authorizations for other types of VA care in the community in November 2015, and in January 2016 (the most recent month for which data were available) about 56 percent of VA care in the community authorizations were routed to the Choice Program. VHA has not eliminated the medical documentation requirement for all other types of VA care in the community, requiring community providers to submit medical documentation before VHA will pay claims for (1) individually authorized inpatient VA care in the community, (2) PC3 care, (3) Millennium Act emergency care, and (4) service-connected emergency care. As discussed earlier in this report, VHA's inability to electronically accept medical documentation from most community providers and the administrative burden of scanning a high volume of paper medical documentation have caused delays in VHA's processing of claims for VA care in the community.

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- **Staffing increases.** VHA officials said that they have recently filled the approximately 300 staff vacancies that resulted from attrition shortly after the October 2014 realignment of claims processing under VHA's Chief Business Office for Purchased Care. The officials also told us that they have supplemented the existing workforce at VHA's claims processing locations by hiring temporary staff and contractors to help address VHA's backlog of claims awaiting processing. In addition, for 2 months in fiscal year 2015, VHA required its claims processing staff to work mandatory overtime, and according to VHA officials, staff are still working overtime on a voluntary basis. At some locations, VHA added second shifts for claims processing staff. As a result, VHA officials told us that VHA was able to decrease its backlog of unprocessed claims for VA care in the community from an all-time high of 736,000 claims in August 2015 to about 453,000 claims as of October 29, 2015.⁵⁴
 - **Deployment of nationwide productivity standards.** On October 1, 2015, VHA introduced new performance plans with nationwide productivity standards for its claims processing staff, and officials estimated that these standards would lead staff to process more claims each day, resulting in a 6.53 percent increase in claims processing productivity over the course of fiscal year 2016.
 - **Improved access to data needed to monitor claims processing performance.** VHA has implemented a new, real-time data tracking system to monitor claims processing productivity and other aspects of performance at its claims processing locations. This tool, which VHA officials refer to as the "command center," permits VHA officials and managers at VHA's claims processing locations to view claims data related to the timeliness of payments and other metrics at the national, claims processing location, and the individual staff level. Previously, many data were self-reported by the claims processing locations. The VHA officials we interviewed said that they monitor these data daily.

⁵⁴VHA defines "backlogged" claims to be those that VHA has received but not processed for 30 days or more. However, VHA's data do not account for paper claims that have been received by VHA claims processing locations but not yet scanned into FBCS. Therefore, VHA's data likely underestimate the number of claims that have been awaiting processing for more than 30 days.

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- **New scanning equipment.** VHA recently purchased new scanning equipment for 73 of its 95 claims processing locations, including the claims processing location we visited with the small, desktop scanners. The agency awarded a contract in November 2015, and officials said that VHA had installed this new equipment at almost all sites as of January 15, 2016. They expected that installation would be completed at the few remaining sites by the end of January 2016.
 - **Improvement of cost estimation tools.** In January 2016, VHA deployed an FBCS enhancement that is intended to improve VHA's ability to estimate obligations for VA care in the community within FBCS. VHA officials said this should help them better estimate costs to help ensure that adequate funds are available to pay claims for VA care in the community services at the time the claims are processed. However, staff at VA medical facilities still must manually enter estimated obligations into VHA's systems for tracking the availability of funds on a monthly basis, because this information cannot be automatically transferred from FBCS.

VHA is Examining Options for Modernizing Its Claims Processing System and Estimates Implementing New Technology and Other Solutions Will Take At Least 2 Years

VHA officials we interviewed in the course of our work acknowledged that the recent steps they have taken to improve claims processing timeliness—such as hiring temporary staff and contractors and mandating that claims processing staff work overtime—are not sustainable in the long term. The officials said that if the agency is to dramatically improve its claims processing timeliness, comprehensive and technologically advanced solutions must be developed and implemented, such as modernizing and upgrading VHA's existing claims processing system or contracting out the claims processing function. On October 30, 2015, VHA reported to Congress that it has plans to address these issues as part of a broader effort to consolidate VA care in the community programs.⁵⁵ However, the agency estimates that it will take at least 2 years to implement solutions that will fully address all of the challenges now faced by its claims processing staff and by providers of VA care in the community services. According to VHA officials, the success of this

⁵⁵Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, (Washington, D.C.: Oct. 30, 2015). The VA Budget and Choice Improvement Act required VA to develop a plan for consolidating its existing VA care in the community programs. The plan was due to Congress no later than November 1, 2015. Pub. L. No. 114-41, § 4002, 129 Stat. 443, 461 (2015).

long-term modernization plan will also hinge on significant investments in the development and deployment of new technology.

In its October 2015 plan, VHA stated that it expects it will significantly increase its reliance on community providers to deliver care to veterans in the coming years. In addition, VHA plans to adopt many features or capabilities for its claims processing system that are similar to Medicare's and TRICARE's claims processing systems, including (1) greater automatic adjudication of claims, (2) automating the entry of authorizations, (3) establishing a mechanism by which community providers can electronically submit medical records, (4) creating a Web-based portal for community providers to check the status of their claims, and (5) establishing a nationwide provider customer service system with dedicated staff so that other staff can focus on claims processing. According to this plan, in fiscal year 2016 VHA will examine potential strategies for developing these capabilities—including the possibilities of contracting for (1) the development of the claims processing system only or (2) all claims processing services, so that contractors, rather than VHA staff, would be responsible for processing claims (similar to Medicare and TRICARE).

Based on statements made by community providers that participated in our review, it is critical for VA to succeed in achieving its goal of deploying a modernized claims processing system. Without (1) significantly improving the timeliness of its payments and (2) addressing community providers' concerns about the administrative burden of obtaining VHA payments and the agency's lack of responsiveness when they inquire about unpaid claims, VHA risks losing the cooperation of these providers as it attempts to transition to a future care delivery model that would heavily rely on them to deliver care to veterans.

Since the release of its October 2015 plan for consolidating VA care in the community programs, VHA has done some of the preliminary work needed to modernize its claims processing system. After issuing a request for interested parties to share information, VHA held an industry day in December 2015, where about 80 participants discussed with VHA the extent to which contractors could help support core functions—including claims processing—for the consolidated VA care in the community program VHA plans to establish. VHA officials said they used information gathered from this industry day to inform the development of a draft performance work statement and a draft operations manual for a consolidated VA care in the community program. VA publicly posted these documents in February 2016 and accepted written comments,

questions, and other feedback from industry for about two weeks. VA plans to use these responses to help inform any future requests for proposals related to the consolidation of VA care in the community programs and the improvement of claims processing timeliness.

VA's plan for consolidating its care in the community programs outlines its approach to addressing deficiencies in VHA's claims processing system. VA's consolidation plan represents a major undertaking that depends, in part, on obtaining congressional approval for legislative changes and budget requests and revamping VA's information technology systems. Leading practices call for careful planning and for developing an implementation strategy to help ensure that needed changes are made in a timely and cost-effective manner. When facing major challenges similar to the ones VHA faces to modernize its claims processing system, leading practices call for results-oriented organizations to focus on developing robust, comprehensive plans that (1) define the goals the organization is seeking to accomplish, (2) identify specific activities to obtain desired results, and (3) provide tools to help ensure accountability and mitigate risks. In prior work, we have determined that sound plans include the following components (among others):

- **Goals, objectives, activities, and performance measures.** This component addresses what the plan is trying to achieve and how it will achieve those results, as well as the priorities, milestones, and performance measures to monitor and gauge results.
- **Resources, investments, and risks.** This component addresses what the plan will cost, the sources and types of resources and investments needed, and where resources and investments should be targeted while assessing and managing risks.⁵⁶

To date, VHA has not communicated to Congress or other external stakeholders a plan for modernizing its claims processing system that clearly addresses the components of a sound plan identified above. In particular, VHA has not communicated (1) a detailed schedule for developing and implementing each aspect of its new claims processing

⁵⁶The remaining components of sound plans include (1) purpose, scope, and methodology; (2) problem definition, causes, and operating environment; (3) roles, responsibilities, and coordination; and (4) integration among and with other entities. See [GAO-04-408T](#) and [GAO-09-398](#).

system; (2) the estimated costs for developing and implementing each aspect of the system; and (3) performance goals, measures, and interim milestones that VHA will use to evaluate progress, hold staff accountable for achieving desired results, and report to stakeholders the agency's progress in modernizing its claims processing system. The communication of such a plan is also consistent with federal internal control standards for information and communication, which call for agencies to internally and externally communicate the necessary quality information to achieve the entity's objectives.⁵⁷

That VHA has not yet communicated a detailed plan but has stated that it expects to deploy a modernized claims processing system as early as fiscal year 2018 is cause for concern, especially given VA's past failed attempts to modernize key information technology systems. Our prior work has shown that VHA's past attempts to achieve goals of a similar magnitude—such as modernizing its systems for (1) scheduling outpatient appointments in VA medical facilities, (2) financial management, and (3) inventory and asset management—have been derailed by weaknesses in project management, a lack of effective oversight, and the failure of pilot systems to support agency operations.⁵⁸ For example, we found:

- VA undertook an initiative in 2000 to replace the outpatient scheduling system but terminated the project after spending \$127 million over 9 years.
- VA has been trying for many years to modernize or replace its financial management and inventory and asset management systems but has faced hurdles in carrying out these plans. In 2010, VA canceled a broad information technology improvement effort that would have improved both of these systems and at the time was

⁵⁷See [GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

⁵⁸See GAO, *Information Technology: Management Improvements Are Essential to VA's Second Effort to Replace its Outpatient Scheduling System*, [GAO-10-579](#) (Washington, D.C.: May 27, 2010); GAO, *Information Technology: Actions Needed to Fully Establish Program Management Capability for VA's Financial and Logistics Initiative*, [GAO-10-40](#) (Washington, D.C.: Oct. 26, 2009); and GAO, *Veterans Health Care: VHA Has Taken Steps to Address Deficiencies in its Logistics Program, but Significant Concerns Remain*, [GAO-13-336](#) (Washington, D.C.: April 17, 2013).

estimated to cost between \$300 million and \$400 million.⁵⁹ By September 2, 2009 (just before the project's cancellation) VA had already spent almost \$91 million of the \$300 million to \$400 million that was originally estimated. A previous initiative to modernize these systems was underway between 1998 and 2004, but after reportedly having spent more than \$249 million on development of the replacement system, VA discontinued the project because the pilot system failed to support VHA's operations.

According to VHA officials, instead of investing in administrative systems such as the claims processing system, outpatient scheduling system, financial management systems, or the inventory and asset management system, VA has prioritized investments in information technology enhancements that more directly relate to patient care. As such, VHA officials said they have had little success in gaining approval and funding for information technology improvements for these administrative systems.

Conclusions

VHA's average claims processing timeliness in fiscal year 2015 was significantly lower than Medicare's and TRICARE's timeliness and far below its own standard of paying 90 percent of claims within 30 days. If this situation persists, it could have very real consequences on veterans' access to care. Presently, VHA (through its TPAs), is attempting to improve veterans' access to care by establishing a robust network of community health providers under its VA care in the community programs. However, absent a responsive provider customer service component and timely payment of claims, many community providers may opt not to participate in VA's network, thereby narrowing the choices veterans have for seeking care from community providers. In turn, this could lead to longer wait times for veterans to receive care and a greater reliance on VA medical centers, some of which have already experienced long wait times for veterans seeking care. Moreover, millions of dollars in interest penalties resulting from the late payment of claims by VHA could dilute the funding available for the direct delivery of care to veterans.

⁵⁹The portion of the broad information technology improvement effort that VA canceled in 2010 pertaining to the update of VHA's inventory and asset management system was not officially terminated until 2011.

To its credit, VHA has implemented several short-term initiatives intended to address ongoing challenges and improve its timeliness in paying community providers. These initiatives include increasing the number of staff processing claims, purchasing new scanning equipment, holding claims processing staff accountable through new productivity standards, and developing a tracking system to monitor claims processing performance. By VHA's own admission, however, these short-term initiatives will not resolve all challenges that have long impeded its claims processing timeliness, and many of these initiatives are not sustainable over the longer term. VHA plans to address the remaining challenges through its longer term effort to implement a consolidated VA care in the community program in fiscal year 2018 or later.

VHA's sweeping changes are likely to be costly, and to achieve the goals of this initiative it will be important to have a high level of planning and effective project management, and communication with multiple stakeholders. As we have reported in prior work, VHA's plans to achieve goals of a similar magnitude—such as the modernization of its systems for outpatient appointment scheduling, financial management, and inventory and asset management—have been derailed by weaknesses in project management and a lack of effective oversight. Therefore, if VHA's current initiative is to be successful, it is essential that VHA develop a sound implementation plan and an effective project management strategy as it proceeds. Otherwise, the agency risks spending valuable resources on new systems and processes that may not significantly improve VHA's claims processing timeliness. As part of its implementation plan, it is critical that VHA identify implementation steps and develop the ability to measure and externally communicate its progress to the Congress and other stakeholders. It is also important that VHA be held accountable for achieving major components of the initiative and adhering to its timeline, as stated in its 2015 plan for consolidating VA care in the community programs.

Recommendation for Executive Action

To help provide reasonable assurance that VHA achieves its long-term goal of modernizing its claims processing system, the Secretary of Veterans Affairs should direct the Under Secretary for Health to ensure that the agency develops a sound written plan that includes the following elements:

- a detailed schedule for when VHA intends to complete development and implementation of each major aspect of its new claims processing system;

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- the estimated costs for implementing each major aspect of the system; and
 - the performance goals, measures, and interim milestones that VHA will use to evaluate progress, hold staff accountable for achieving desired results, and report to stakeholders the agency's progress in modernizing its claims processing system.

Agency Comments and Our Evaluation

We provided a draft of this report to VA, HHS, and DOD for comment. VA provided written comments on the draft report, and we have reprinted these comments in Appendix V. In its comments, VA concurred with our recommendation and said that VHA plans to address it when the agency develops an implementation strategy for the future consolidation of its VA care in the community programs. VA also provided technical comments, which we have incorporated as appropriate. HHS had no general comments on the draft report but provided technical comments, which we have addressed as appropriate. DOD had no general or technical comments on the draft report.

We are sending copies of this report to the Secretary of Veterans Affairs, the Secretary of Health and Human Services, the Secretary of Defense, appropriate congressional committees, and other interested parties. This report is also available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



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Director, Health Care

Appendix I: Characteristics of Selected Care in the Community Programs of the Department of Veterans Affairs (VA)

Characteristics of program	Selected Types of VA Care in the Community ^a			
	Individually authorized care	Emergency care	Patient-Centered Community Care (PC3)	Veterans Choice Program
When did the Veterans Health Administration (VHA) begin offering this type of care in the community?	VHA was first authorized to grant veterans individual authorizations to receive care in the community in 1945, and the current statutory authority was codified in 1986. ^b This is the primary means by which VHA has traditionally purchased care from community providers.	VA may purchase emergency care from community providers under two different authorities: ^c <ol style="list-style-type: none"> Emergency care related to a veteran's service-connected disability. This program was established in 1973. Emergency care not related to a veteran's service-connected disability. This program was established by the Veterans Millennium Health Care and Benefits Act in 1999 and is commonly referred to as Millennium Act emergency care. 	VA created PC3 in 2013 under existing statutory authority, and fully implemented the program in April 2014. Under PC3, two third party administrators (TPA) developed regional networks of community providers to deliver care to veterans. ^d	The Veterans Choice Program was created by the Veterans Access, Choice, and Accountability Act of 2014. ^e VHA introduced the program in November 2014 and expanded it in April 2015 and December 2015. To administer this program, VHA modified its contracts with the two TPAs it selected to administer the PC3 program. These contractors are responsible for enrolling community providers in their networks or establishing Choice Provider Agreements with the providers.

Appendix I: Characteristics of Selected Care in the Community Programs of the Department of Veterans Affairs (VA)

Characteristics of program	Selected Types of VA Care in the Community ^a			
	Individually authorized care	Emergency care	Patient-Centered Community Care (PC3)	Veterans Choice Program
When can a veteran access this type of VA care in the community?	A veteran may be individually authorized to receive care when they cannot access a particular specialty care service from a VA medical center (because the service is not offered), they would have to wait too long for an appointment, or they would have to travel a long distance to a VA medical center.	<p>A veteran may access emergency care for a condition related to a service-connected disability when a prudent layperson</p> <ul style="list-style-type: none"> would classify the condition as an emergency, and would have deemed it unreasonable for the veteran to access the care at a VA or other federal facility.^f <p>In addition to meeting the above criteria, a veteran may access Millennium Act emergency care (for a condition not related to a service-connected disability) if services were rendered before they were stable for transfer to a VA or other federal facility, and when the veteran:</p> <ul style="list-style-type: none"> was enrolled in and accessed care from a VA clinician in the 24 months preceding the emergency care, is financially liable to the community provider, has no entitlement under another health plan contract (such as Medicare), and has no recourse against a third party that would wholly extinguish liability to the community provider. 	The criteria for a veteran to be eligible to access the PC3 program are the same as those for individually authorized care.	<p>A veteran is eligible for this program when they:^g</p> <ul style="list-style-type: none"> cannot get a VA appointment within 30 days from the veteran's or physician's preferred date; or live more than 40 miles driving distance from the nearest VA medical center with a full-time primary care physician; or would have to travel by air, boat, or ferry to the VA medical center closest to their home; or face unusual or excessive burden (such as geographic challenges) in traveling to a VA medical center; or have specific health care needs that warrant participation (including the nature and frequency of care); or live in a state or territory without a full-service VA medical center.^h

Appendix I: Characteristics of Selected Care in the Community Programs of the Department of Veterans Affairs (VA)

Characteristics of program	Selected Types of VA Care in the Community ^a			
	Individually authorized care	Emergency care	Patient-Centered Community Care (PC3)	Veterans Choice Program
Is there a timely filing requirement for community providers?	Providers have 6 years after the date of service to submit a claim to VHA.	<ul style="list-style-type: none"> For emergency care related to a veteran's service-connected disability, providers must submit claims within 2 years of the date of service. For care unrelated to a veteran's service-connected disability, providers must submit claims within 90 days of the date of service.ⁱ 	Providers must submit claims electronically within 180 business days of the end of the episode of care.	Providers must submit claims electronically within 180 business days of the end of the episode of care.
Generally, what are the payment rates for community providers delivering services under this program?	Medicare rates, unless the provider has an existing contract and negotiated rates with an individual VA medical facility	<ul style="list-style-type: none"> Medicare rates for emergency care related to a veteran's service-connected disability 70 percent of Medicare rates for emergency care unrelated to a veteran's service-connected disability 	Rates are negotiated between community providers and VA's TPAs. These are reportedly a negotiated percentage of local Medicare rates.	Medicare rates
Are community providers required to submit medical documentation as a condition of claims payment?	Sometimes. <ul style="list-style-type: none"> For individually authorized outpatient care: the authorization will indicate whether documentation is required. For individually authorized inpatient care: at a minimum, providers must submit the discharge summary to VA. 	Yes. Community providers must submit medical documentation so that VA clinicians can determine whether the care was related to the veteran's service-connected disability and whether the condition for which the veteran sought treatment meets the prudent layperson standard of an emergency.	Yes. Under their contracts with VA, the TPAs must collect medical documentation from community providers and return it to VA in a timely manner.	No. ^j

Source: GAO analysis of VA policies and documents. | GAO-16-353

^aIn addition to the programs described in this table, VA is also authorized to purchase care from Department of Defense and Indian Health Service facilities, community nursing homes, and community-based home health providers. 38 U.S.C. §§ 1710, 1720, 8111, and 8153.

^b38 U.S.C. § 1703.

^c38 U.S.C. § 1728 and 38 U.S.C. § 1725.

^dThe two TPAs that currently hold these contracts are TriWest Healthcare Alliance and Health Net Federal Services.

^ePub. L. No. 113-146, 128 Stat. 1754 (2014).

^fA medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or

**Appendix I: Characteristics of Selected Care in
the Community Programs of the Department of
Veterans Affairs (VA)**

health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

⁹Veterans Health Administration, Veterans Choice Program Eligibility Details (Washington, D.C.: U.S. Department of Veterans Affairs, 2015).

¹⁰Specifically, veterans who reside in Alaska, Hawaii, New Hampshire, or a U.S. territory would be eligible for the program under this criterion. Veterans residing in New Hampshire are only eligible if they reside more than 20 miles away from the White River Junction VA medical center, which is located in Vermont.

¹¹The claim must be filed within 90 days of the latest of the following: the date of discharge; date of death, provided death occurred during transport to or stay in an emergency treatment facility; or the date that the veteran exhausted, without success, action to obtain payment or reimbursement from a third party. 38 C.F.R. § 17.1004(d).

¹²On March 1, 2016, VHA stopped requiring community providers to submit medical documentation as a condition of payment for claims for Veterans Choice Program services.

Appendix II: Requirements for the Department of Veterans Affairs' (VA) Payment of Emergency Claims from Community Providers

Criterion	Service-connected emergency care ^a	Nonservice-connected emergency care (Millennium Act care) ^b
Claim was filed in a timely manner	Claim must be filed within 2 years of the date services were rendered.	Claim must be filed within 90 days of the date services were rendered. ^c
Condition meets the prudent layperson standard of an emergency ^d	✓	✓
A VA or other federal medical facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable by a prudent layperson	✓	✓
The services were rendered before the veteran was stable enough for transfer to a VA or other federal medical facility and before the VA or other federal medical facility agreed to accept the transfer	✓	✓
Veteran was enrolled in the VA health care system		✓
Veteran had received care from a VA clinician within the 24 months preceding the emergency care episode		✓
Veteran is financially liable to the community provider of the emergency care		✓
Veteran has no entitlement under another health plan contract (such as Medicare or a private health insurance plan)		✓
Veteran has no recourse against a third party that would wholly extinguish his or her liability to the community provider (e.g., motor vehicle insurance or workers' compensation)		✓
Services were rendered in a hospital emergency department or a similar facility providing emergency care to the public		✓

Source: GAO analysis of VA documents. | GAO-16-353

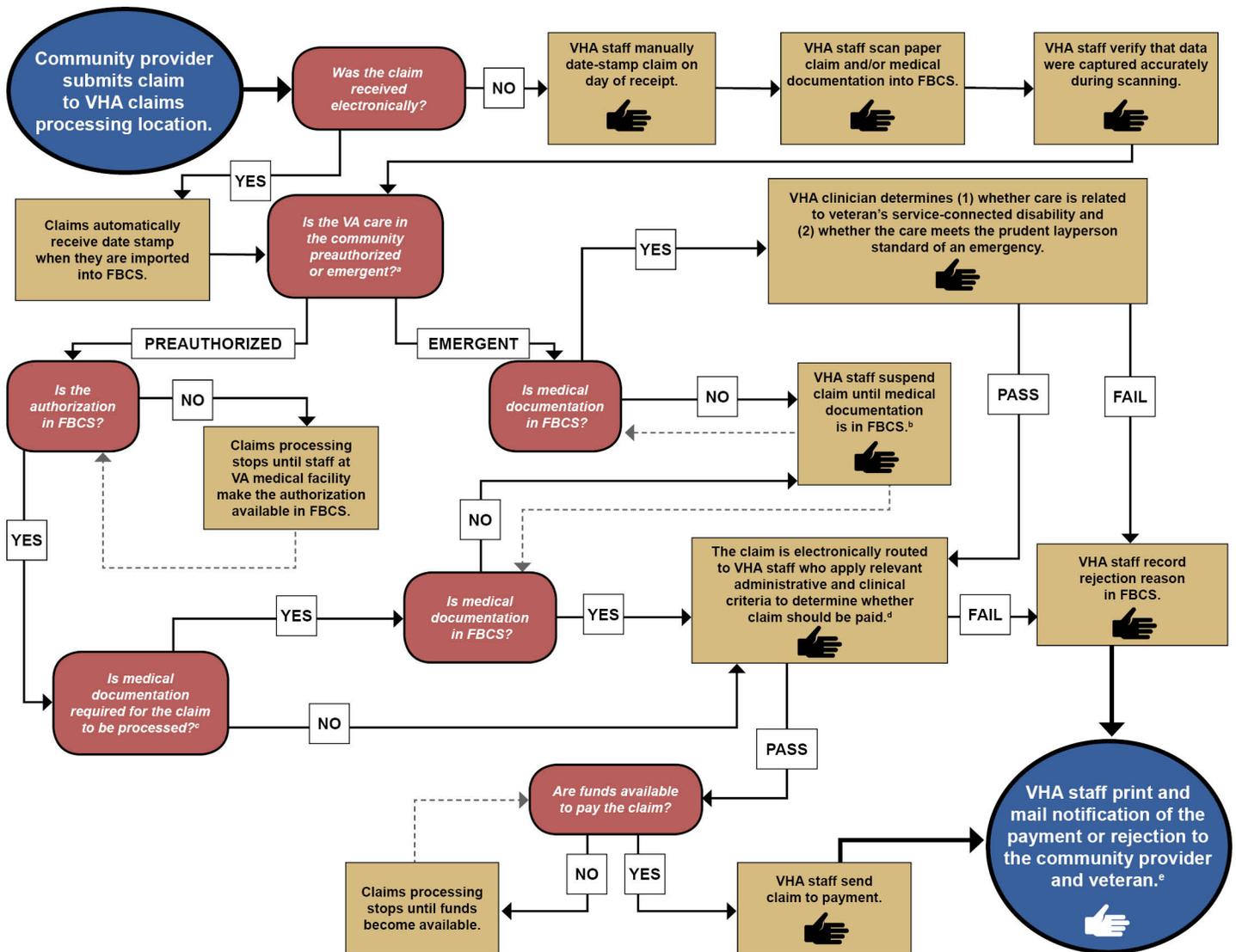
^aService-connected emergency care is for treatment of conditions related to a veteran's service-connected disability. See 38 U.S.C. § 1728.

^b38 U.S.C. § 1725.

^cThe claim must be filed within 90 days of the latest of the following: the date of discharge; the date of death, provided death occurred during transport to or stay in an emergency treatment facility; or the date that the veteran exhausted, without success, action to obtain payment or reimbursement from a third party. 38 C.F.R. § 17.1004(d) (2015).

^dA medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b) (2015). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

Appendix III: Veterans Health Administration's (VHA) Steps for Processing Claims for the Department of Veterans Affairs' (VA) Care in the Community Services as of March 2016



Legend: FBCS=Fee Basis Claims System.

● Start or end of claims processing
 ● Decision point in claims processing
 Claims processing step or action
 Manual claims processing step

Source: VHA (documentation); GAO (illustration). | GAO-16-353

^aVHA has numerous programs through which it purchases VA care in the community services, and these programs have varying rules governing payment rates and requirements for claims processing. The primary means by which VHA has traditionally purchased care from community providers is through individual authorizations. When a veteran cannot access a particular specialty care service

Appendix III: Veterans Health Administration's (VHA) Steps for Processing Claims for the Department of Veterans Affairs' (VA) Care in the Community Services as of March 2016

from a VA medical facility, the veteran's VA clinician may request an individual authorization for the veteran to obtain the service from a community provider. In addition, when care in the community is not preauthorized, VA may purchase two different types of emergency care from community providers: 1) emergency care for a condition that was related to a veteran's service-connected disability and 2) emergency care for a condition not related to a veteran's service-connected disability. The latter care is commonly referred to as Millennium Act emergency care. See Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999) (codified, as amended at 38 U.S.C. § 1725) for emergency care not related to a service-connected disability. See 38 U.S.C. § 1728 for emergency care related to a service-connected disability.

^bMedical documentation may not be in the Fee Basis Claims System (FBCS) because either (1) the community provider has not yet submitted the documentation or because (2) staff at the VHA claims processing location have not yet scanned it into FBCS. According to VHA officials, if a claim has been submitted electronically and a community provider does not submit medical documentation within 45 days of the claim being suspended, FBCS will automatically reject the claim. In these cases, the community provider must resubmit both the claim and medical documentation.

^cVHA requires community providers to submit medical documentation with all claims for individually authorized inpatient care and all emergency care claims. Community providers also may be required to submit documentation with some claims for individually authorized outpatient care.

^dExamples of relevant administrative and clinical criteria include whether the claim met VA's timely filing requirement, whether the veteran has other insurance or legal recourse against a third party, and whether services were rendered beyond the point at which the veteran was stable enough to be transferred to a VA or other federal facility.

^eVHA staff use FBCS to generate notifications for the community provider and veteran about whether the claim was paid or rejected. These notifications are called preliminary fee remittance advice reports and include a listing of claim dates and services, the reasons why payments for any services were rejected, and the payment amounts for approved services.

Appendix IV: Comparison of the Veterans Health Administration's (VHA), Medicare's, and TRICARE's Systems for Processing Claims for Health Care Purchased in the Community

Characteristic of claims processing	VHA	Medicare	TRICARE
Approximately how many individuals were enrolled to receive health care services in fiscal year 2014?	9.1 million veterans	37.5 million elderly and disabled beneficiaries ^a	9.6 million military service members, retirees, and dependents and survivors
What entity processes the agency's claims for care purchased in the community?	Approximately 2,000 VHA staff at 95 claims processing locations ^b	Most Medicare Part A and Part B claims are processed by one of 12 jurisdiction-based Medicare Administrative Contractors (MAC) or four MACs that specialize in processing durable medical equipment claims (some MACs have more than one contract). One of these contractors reported that they employ about 65 claims processors, managers, and support staff in 3 locations.	One contractor subcontracted by the three managed care support contractors (MCSC). ^c According to officials from this contractor, they employ about 650 staff in 3 locations who are responsible for processing claims from the 3 MCSCs.
What was the reported total sum of payments for health care services purchased from community providers by this agency in fiscal year 2014?	\$5.6 billion	\$357.3 billion ^d	\$10.5 billion
About how many health care claims were processed in fiscal year 2014?	13.3 million claims	Over 1.2 billion claims	55.7 million claims
Does the agency have requirements for claims processing timeliness?	Yes. A VHA directive states that 90 percent of all claims must be processed within 30 days of receipt. ^e	Yes. By law, 95 percent of clean claims must be processed (either paid or denied) within 30 days of receipt. ^f In accordance with statute, the Centers for Medicare & Medicaid Services' (CMS) manual for processing Medicare claims states that the remaining claims must be processed within 45 days of receipt. ^g	Yes. The TRICARE Operations Manual states that 98 percent of claims with sufficient information to be processed must be paid or denied within 30 days of receipt. All claims must be processed to completion within 90 days of receipt. ^h

Appendix IV: Comparison of the Veterans Health Administration's (VHA), Medicare's, and TRICARE's Systems for Processing Claims for Health Care Purchased in the Community

Characteristic of claims processing	VHA	Medicare	TRICARE
Does the Prompt Payment Act apply to claims processed for this agency?	Yes. On October 2, 2015, the Department of Veterans Affairs' (VA) Office of General Counsel concluded that the Prompt Payment Act applies to claims for care in the community services that were (1) individually authorized in advance, or (2) delivered by community providers who have contracted with the third party administrators (TPA) to participate in Veterans Choice Program networks ^l	Yes.	Yes.
How does the agency monitor the timeliness of claims processing?	<p>VHA's Chief Business Office for Purchased Care monitors the timeliness of processing for claims from community providers using the following performance metrics:</p> <ul style="list-style-type: none"> a. the percentage of all claims that have been processed—either paid, rejected, or denied—in 30 days or less; b. the percentage of claims awaiting processing that were received less than 30 days ago;^j c. the percentage of claims for individually authorized VA care in the community that were processed in 30 days or less; and d. the percentage of claims for other-than-individually authorized care that were processed in 45 days or less.^k <p>According to Chief Business Office for Purchased Care officials, they have a real-time data tracking system that allows them to monitor claims processing productivity and other aspects of claims processing performance at a national level, for individual claims processing locations, and for individual claims processing staff members.</p>	<p>CMS monitors two key performance metrics:</p> <ul style="list-style-type: none"> a. the percentage of clean claims processed within 30 days of receipt, and b. the percentage of other-than-clean claims processed within 45 days of receipt.^l <p>According to CMS officials, the MACs submit monthly reports to CMS, which include data on claims processing timeliness. These reports are generated by a module within CMS's claims processing software and can be independently verified by CMS.</p>	<p>The Defense Health Agency (DHA) monitors two key performance metrics:</p> <ul style="list-style-type: none"> a. the percentage of claims with sufficient information to be processed that were processed within 30 days of receipt, and b. the percentage of claims that initially lacked sufficient information to be processed that were processed within 90 days of receipt. <p>According to DHA officials, MCSCs submit monthly reports to DHA that include data on the subcontractor's timeliness of claims processing. These data can be independently verified by DHA.</p>

Appendix IV: Comparison of the Veterans Health Administration's (VHA), Medicare's, and TRICARE's Systems for Processing Claims for Health Care Purchased in the Community

Characteristic of claims processing	VHA	Medicare	TRICARE
Does the agency have staff productivity standards or performance incentives for processing claims in a timely manner?	Officials from VHA's Chief Business Office for Purchased Care told GAO that they introduced nationwide staff productivity standards on October 1, 2015.	CMS officials said that they previously included financial incentives in the MACs' contracts to encourage the MACs to meet requirements for claims processing timeliness. After all MACs demonstrated that they were easily meeting these requirements, these financial incentives were removed from the MACs' contracts and replaced by financial incentives to meet other requirements. Officials from one MAC GAO visited reported that they have productivity standards in place for their claims processing staff.	DHA officials said that the MCSCs are penalized \$1 for every claim that the subcontractor does not process in a timely manner. The subcontractor that processes TRICARE claims reported that it has productivity standards in place for its claims processing staff.
Does the agency permit providers to submit both paper-based and electronic claims?	Yes, and less than half of claims are submitted electronically. Officials from VHA's Chief Business Office for Purchased Care reported that community providers submit about 40 percent of claims electronically.	Yes, and nearly all claims are submitted electronically. CMS officials said that as of fiscal year 2014, more than 99 percent of institutional providers and more than 98 percent of practitioners and suppliers submitted claims electronically.	Yes, and nearly all claims are submitted electronically. DHA officials estimate that between 91 and 95 percent of claims are submitted electronically.
Are providers required to submit medical documentation in order for their claims to be processed?	Yes, according to VA policy, providers are required to submit medical documentation for some specific types of claims. <ul style="list-style-type: none"> Individually authorized outpatient care: the authorization will indicate whether documentation is required. Individually authorized inpatient care: at a minimum, providers must submit the discharge summary to VA. Emergency care: medical documentation must be submitted so that the claim can be clinically reviewed to determine whether it meets eligibility criteria for payment.^m Patient-Centered Community Care (PC3): As a condition of their contracts, VA's third party administrators are required to submit medical documentation for all claims. 	No. According to CMS officials, providers only submit medical documentation when requested to do so by a MAC, which would only request the documents if claims were flagged for prepayment review (e.g., a clinical review to determine the medical necessity of the services).	No. According to DHA officials, providers are not required to submit medical documentation in order for claims to be processed, unless a claim is flagged for a prepayment review (such as a claim for an experimental treatment).

Appendix IV: Comparison of the Veterans Health Administration's (VHA), Medicare's, and TRICARE's Systems for Processing Claims for Health Care Purchased in the Community

Characteristic of claims processing	VHA	Medicare	TRICARE
Does the agency permit providers to submit medical documentation electronically?	No. According to VA officials, the agency does not have the capacity to receive medical documentation electronically from community providers.	Yes. According to CMS officials, when medical documentation is requested, the MACs can receive the information electronically via a Web-based portal.	Yes. According to DHA officials, when medical documentation is requested, the TRICARE contractor can receive the information electronically via a Web-based portal.

Source: GAO analysis of documents and interviews with officials from VA, CMS, DHA, one Medicare Administrative Contractor, and the contractor responsible for processing TRICARE claims. | GAO-16-353

^aThere are about 37.5 million beneficiaries enrolled in original Medicare (or Medicare fee-for-service) and 54 million total Medicare enrollees. Those not enrolled in original Medicare are enrolled in Medicare Advantage, the private health plan alternative to original Medicare.

^bClaims processing for multiple VA medical facilities may be processed by staff in a single location.

^cAccording to DHA officials, DHA does not require the three MCSCs to contract with the same entity for claims processing; however, all three MCSCs have selected the same contractor to perform this function.

^dThis includes only payments for Medicare fee-for-service claims and excludes payments for Medicare Advantage (the private health plan alternative to Medicare fee-for-service) and Medicare Part D (the outpatient prescription drug benefit provided through private plans).

^eVeterans Health Administration, Timeliness Standards for Processing Non-VA Provider Claims, VHA Directive 2010-005 (Washington, D.C.: Jan. 27, 2010).

^fA "clean claim" has no defect or impropriety (including a lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. 42 U.S.C. § 1395h(c)(2)(B). Other claims require additional investigation or development before they can be paid. Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Publication 100-04 (Baltimore, MD: May 15, 2015).

^g42 U.S.C. § 1395ff(a)(2).

^hTRICARE MCSCs are subject to claims processing timeliness requirements outlined in law and in the TRICARE Operations Manual. The requirements listed in the Operations Manual are more stringent than in the law, which states that 95 percent of clean claims must be processed within 30 days of submission to the claims processor and that all clean claims must be processed within 100 days of submission to the claims processor. 10 U.S.C. § 1095c(a).

ⁱThe decision also specified that the Prompt Payment Act does not apply to care authorized by the Choice Act pursuant to interagency or provider agreements.

^jVHA's goal is that 80 percent of claims awaiting processing were received for processing within the last 30 days.

^kVHA officials refer to these claims as "unauthorized claims." These are claims for care that was not individually authorized in advance of the veteran receiving care, including claims for service-connected emergency care and claims for Millennium Act emergency care.

^lCMS monitors numerous metrics, including ones related to (1) the amount of interest penalties for late payments, (2) the percentage of paper claims processed in 29 to 30 days, and (3) the percentage of electronic claims processed in 14 to 30 days.

^mIn a May 2013 report that analyzed spending and utilization of VA care in the community between fiscal years 2008 and 2012, GAO found that preauthorized outpatient care accounted for about 36 percent of spending, preauthorized inpatient care accounted for about 23 percent of spending, and inpatient and outpatient emergency care accounted for about 13 percent of spending on VA care in the community between fiscal years 2008 and 2012. The remaining spending on VA care in the community was for home health care, community nursing home care, dental care, and VA compensation and pension exams. GAO, VA Health Care: Management and Oversight of Fee Basis Care Need Improvement, [GAO-13-441](#) (Washington, D.C.: May 31, 2013).

Appendix V: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

April 22, 2016

Mr. Randall B. Williamson
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VETERANS' HEALTH CARE: Proper Plan Needed to Modernize System for Paying Community Providers**" (GAO-16-353). VA agrees with GAO's conclusions and concurs with GAO's recommendation to the Department.

The enclosure sets forth the action to be taken to address the GAO draft report recommendation.

Sincerely,


Robert D. Snyder
Chief of Staff

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***“VETERANS’ HEALTH CARE: Proper Plan Needed to Modernize System for
Paying Community Providers”***
(GAO-16-353)

GAO Recommendation: To help provide reasonable assurance that VHA achieves its long-term goal of modernizing its claims processing system, the Secretary of Veterans Affairs should direct the Under Secretary for Health to ensure that the agency develops a sound written plan that includes the following elements:

- a detailed schedule for when VHA intends to complete development and implementation of each major aspect of its new claims processing system;
- the estimated costs for implementing each major aspect of the system; and
- performance goals, measures, and interim milestones that VHA can use to evaluate progress, hold staff accountable for achieving desired results, and report its progress in modernizing its claims processing system to stakeholders.

VA Comment: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability). The Veteran Health Administration’s (VHA) actions will modernize its existing claims processing system and provide structure for measuring its progress.

The Office of the Deputy Under Secretary for Health for VA Community Care, in collaboration with other offices, is in the process of developing the Community Care Implementation Strategy and related plans that will define goals, activities, priorities, timelines, and performance measures. This activity is an important component of the overall plan we outlined to Congress in October 2015. We recognize the inherent complexity, magnitude, and impact of consolidating our community care programs and the associated information technology updates required to carry out the plan. Because of this, we are taking the important steps necessary to develop an Implementation Strategy that will include the design and specific details regarding transitioning, deployment of technologies, resourcing, servicing parameters, accountability, and quality controls.

As part of this work, VA has completed an alternatives analysis to evaluate the costs, benefits, and risks of future investments in a more efficient and effective health care claims processing environment. Based on this analysis, we determined that the best path forward would be to leverage, to the greatest extent possible, existing industry capabilities and expertise to improve and modernize the way VA handles claims. In addition, lessons learned from the Patient Centered Community Care (PC3)/Veterans Choice Program contract have revealed that existing health care plans have access to state-of-the-art technologies and systems, making them a viable and economic option for creating a scalable and flexible claims processing environment. We are looking to improve upon the current contracting model in the near-term via incorporation of lessons learned.

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
***“VETERANS’ HEALTH CARE: Proper Plan Needed to Modernize System for
Paying Community Providers”***
(GAO-16-353)

VA is aggressively working towards a future vision for community care. While we do that, we also continue to make important strides in meeting staffing needs, and improving our processes and technology so that we can better support community providers as they furnish care to Veterans. Since August 2015, aged inventory has been reduced by over 52 percent (from 736,000 aged claims to a current inventory of 355,000). As of March 25, 2016, 81.97 percent of authorized claims (clean claims) are less than 30 days old. Claims processing for all claims have improved 14 percentage points from 64 percent in August 2015, to 78 percent currently. Fiscal Year 2016 average days to process authorized claims is currently at 27 days. With the full implementation of new scanning equipment in January 2016, we have completely addressed the scanning delays referenced in the GAO report. Additionally, new processes and metrics implemented in July 2015 (the VA Community Care Claims Dashboard) have improved the monitoring and sustainability of claims processing improvements. We are now able to certify that all incoming paper claims are appropriately scanned on the day of receipt. VA's emphasis on claims processing improvements will continue until the most pressing issues are fixed and while we position VA for the future operating environment.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; Elizabeth Conklin; Christine Davis; Krister Friday; Jacquelyn Hamilton; Alexis C. MacDonald, and Vikki Porter were major contributors to this report.

Related GAO Products

Veterans' Health Care: Preliminary Observations on VHA's Claims Processing Delays and Efforts to Improve the Timeliness of Payments to Community Providers. [GAO-16-380T](#). (Washington, D.C.: Feb. 11, 2016).

VA's Health Care Budget: Preliminary Observations on Efforts to Improve Tracking of Obligations and Projected Utilization, [GAO-16-374T](#) (Washington, D.C.: Feb. 10, 2016).

VA Health Care: Actions Needed to Improve Monitoring and Oversight of Non-VA and Contract Care. [GAO-15-654T](#). (Washington, D.C.: June 1, 2015).

VA Health Care: Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care. [GAO-14-696T](#). (Washington, D.C.: June 18, 2014).

VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit, [GAO-14-175](#). (Washington, D.C.: March 6, 2014).

VA Health Care: Management and Oversight of Fee Basis Care Need Improvement. [GAO-13-441](#). (Washington, D.C.: May 31, 2013).

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