



Testimony

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VETERANS' HEALTH CARE

Preliminary Observations on VHA's Claims Processing Delays and Efforts to Improve the Timeliness of Payments to Community Providers

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Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee:

I am pleased to be here today to discuss our ongoing work related to the plans of the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA) to consolidate its care in the community programs and improve the efficiency, accuracy, and timeliness of its payments to non-VA community providers. The majority of veterans utilizing VHA health care services receive care in VHA-operated medical facilities, such as VA medical centers or community-based outpatient clinics. However, to help ensure that veterans are provided timely and accessible care, the agency has purchased health care services from 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 care at a VA medical facility. Under certain circumstances, VA is also authorized to purchase emergency care from community providers.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

¹For the purposes of this statement, 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.

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 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.

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 grown considerably in recent years. In fiscal year 2015, VA obligated about \$10.1 billion for its care in the community programs for about 1.5 million veterans.⁴ Just three years earlier, in fiscal year 2012, VA spent about \$4.5 billion on care in the community programs 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 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. During a June 3, 2015, hearing of this Subcommittee, several witnesses testified about VHA's continued lack of

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 November 9, 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 October 29, 2015. Total fiscal year 2015 expenditures for VA care in the community are expected to be closer to \$10.1 billion.

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.: August 18, 2010).

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

timeliness in paying claims for VA care in the community services.⁷ 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.

My statement today will draw from our ongoing work examining the timeliness of VHA's payments to community providers and its plans for addressing challenges that have impeded the timeliness of claims processing and payment.⁹ We began this work in March 2015 and plan to issue a final report this spring. In particular, this statement reflects our preliminary observations about:

1. VHA's claims processing timeliness in fiscal year 2015, and how this timeliness compares to Medicare's and TRICARE's;
2. the factors that have impeded the timeliness of VHA's claims processing and payment;
3. providers' experiences with VHA's claims processing; and
4. VHA's recent actions and plans to improve the timeliness of claims processing and payments for VA care in the community programs.

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.: October 28, 2015).

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

⁹The 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 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. Pub. 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 families. 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 statement, we focus on the purchased care component of TRICARE.

To provide preliminary observations from our ongoing work examining these questions, we reviewed applicable policies; interviewed officials from VHA, the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services agency that administers Medicare; and the Defense Health Agency (DHA), the Department of Defense agency that administers TRICARE; and obtained fiscal year 2015 data on claims processing timeliness from VHA, CMS, and DHA.

To assess the reliability of VHA's, CMS's, and DHA's data on claims processing timeliness in fiscal year 2015, we interviewed knowledgeable agency officials about their respective data sources and methods for collecting data.¹⁰ 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 statement, we determined that VHA's 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, but note the limitations of VHA's data in making the comparisons.

We also used VHA data on the timeliness of payments for claims that were processed between February 2014 and February 2015—the most recent data available when we began our study—to select a non-random sample of 4 VHA claims processing locations, where we conducted site visits in May and June 2015.¹¹ 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 2015.¹² We reviewed documentation for 156 claims in all and interviewed managers or staff at the 4 VHA claims processing locations to identify factors affecting the timeliness of

¹⁰From 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.

¹¹The 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). The four claims processing locations we visited are located in St. Louis, MO; Helena, MT; Columbia, SC; and Pearl, MS.

¹²We 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.

payments for these claims.¹³ We also (1) interviewed officials from a non-random sample of 12 community providers that had submitted claims to the 4 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.¹⁴ 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 4 VHA claims processing locations we visited.

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 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. Similarly, 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.

We are conducting the work upon which this statement is based 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

¹³We 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 one 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 that were 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.

¹⁴To 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.

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We shared our preliminary observations with VA, CMS, and DHA. All three agencies provided us with technical comments, which we have incorporated as appropriate.

Background

Oversight of VA Care in the Community

In response to a provision of the Veterans Access, Choice, and Accountability Act of 2014 (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 and VA medical centers to VHA's Chief Business Office for Purchased Care.¹⁵ Previously, VHA's networks and medical facilities were responsible for managing their own budgets 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.

Types of VA Care in the Community Services

VA has several different programs through which it purchases VA care in the community services.¹⁶

- **Individually authorized care.** The primary means by which VA has traditionally purchased care from community providers is through

¹⁵Pub. 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, each responsible for managing and overseeing medical facilities within a defined geographic area. Networks oversee the day-to-day functions of VA medical facilities that are within their boundaries. Each VA medical facility is assigned to a single network. At the start of fiscal year 2016, there were 21 Veterans Integrated Service Networks, but VA is in the process of consolidating some networks so that by the end of fiscal year 2018, there will be 18 networks.

¹⁶In addition to the programs described here, 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.

individual authorizations.¹⁷ 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 reimburse the provider on a fee-for-service basis.

- **Emergency Care.** 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 or associated with or aggravating a veteran’s service-connected disability and 2) emergency care for conditions not related to veterans’ service-connected disabilities. The latter care is commonly referred to as Millennium Act emergency care.¹⁸
- **Patient-Centered Community Care (PC3) and the Veterans Choice Program.** Established in 2013 and 2014, respectively, these programs are administered by two third-party administrators (TPA), with whom VA has contracted to create and maintain networks of primary and specialty care providers willing to treat veterans when they cannot feasibly access services from VA medical facilities.¹⁹ The TPAs are responsible for making appointments with their network providers on behalf of veterans once VA medical facilities notify the TPAs that the veterans are authorized to receive care from community providers.

The rates at which community providers are reimbursed by VA vary depending on whether the care is preauthorized or emergency care, and whether the providers are enrolled in the PC3 or Veterans Choice

¹⁷38 U.S.C. § 1703.

¹⁸See 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(a)(1)-(3) for emergency care related to a service-connected disability.

¹⁹The two TPAs that currently hold these contracts are TriWest Healthcare Alliance and Health Net Federal Services.

Program networks. 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 the TPAs.

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.²⁰ 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 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 1 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.

²⁰If 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.

Table 1: Veterans Health Administration’s (VHA) Steps for Processing Claims for Care in the Community

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 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 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 rejection reasons for 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.
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 funds are released. Claims are then released for payment; VA’s financial services center issues an electronic payment to the community provider or the 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-16-380T

VHA, Medicare, and TRICARE Claims Processing Timeliness Requirements

VHA, CMS, and DHA all have requirements for claims processing timeliness. See table 2.

Table 2: Claims Processing Timeliness Requirements

Agency	Requirement
Veterans Health Administration (VHA)	A VHA directive states that 90 percent of all claims for VA care in the community 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 CMS's manual for processing Medicare claims states that the remaining claims must be processed within 45 days of receipt.
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. It 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. ^c

Source: GAO analysis of VHA, CMS, and DHA policies. | GAO-16-380T

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

^cBy 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).

Preliminary Analyses Suggest VHA's Claims Processing Was Significantly Less Timely Than Medicare's and TRICARE's in Fiscal Year 2015, and VHA's Data Likely Overstate its Performance

Our preliminary work shows that 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.²¹ 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.²² According to CMS and DHA officials, the vast majority of Medicare and TRICARE claims are submitted electronically.²³

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, which VHA officials told us 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 its systems can only calculate timeliness on the basis of the date the claim is entered into

²¹VHA'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.

²²The 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.

²³Officials 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.

FBCS.²⁴ 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.²⁵ However, FBCS cannot electronically read the dates that are manually stamped on paper claims, so the scan date becomes the date used to calculate claims processing timeliness.

Our preliminary review raises questions about whether staff at VHA's claims processing locations are following the agency's policy for promptly scanning paper claims. We do not know the extent of delays in scanning paper claims at all of VHA's claims processing locations. However, our preliminary 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 creation dates for 86 of the 94 paper claims in our sample and the dates the claims were scanned into FBCS.²⁶ Based on this analysis, we found

²⁴VHA 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 their future 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.

²⁵In contrast, electronic claims automatically receive an electronic date-stamp when they are imported into FBCS.

²⁶Our estimate of the 2-week delay in scanning paper claims factored in 2 days for the paper claims to be mailed to VHA by the community providers. It also excluded 8 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.

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 this analysis. 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.²⁷ However, the staff said they do 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 preliminary 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.²⁸ 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,

²⁷Claims 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 or a condition that aggravated a service-connected disability must be received within 2 years.

²⁸See [GAO-14-175](#).

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 these 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.

Preliminary Analyses Indicate that Technology Limitations and Related Staffing Shortages Have Delayed VHA's Claims Processing

VHA cannot accept medical documentation electronically

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

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.²⁹ 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

²⁹For 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.

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 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 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 veterans obtain services from community providers, staff at VA medical facilities must indicate in the veteran's VA electronic health record (a system separate from FBCS) that the service or services have been authorized, and then they 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.³⁰

In our 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.

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

³⁰A 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.

Weaknesses in FBCS and VHA's financial management systems have also delayed claims payments

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.

According to staff at three of the four claims processing locations we visited, payments on some VA care in the community claims are delayed when VHA does not have funds available to pay them, a problem that occurs in part 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 improve 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 Veterans Integrated Service Networks 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. VHA uses historical data from FBCS to estimate obligations on a monthly basis. According to VHA officials, 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, FBCS does not fully interface with 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. Our initial work shows that payments for 5 of the 156 claims we reviewed from four claims processing locations were delayed because funds were unavailable, resulting in payment delays that ranged from 1 to 215 days.

Inadequate equipment delays scanning of 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 between fiscal year 2012 and fiscal year 2015.)

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



Source: VHA (data); GAO (illustration). | GAO-16-380T

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 ongoing 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 ongoing 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 their 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 called preliminary fee remittance advice reports and mail them to the providers and TPAs.³¹ 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

³¹The 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.

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 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.³²

³²VHA 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 Filled Staff Vacancies, Introduced Productivity Standards, Invested in Scanning Equipment, and Taken Other Steps to Improve Claims Processing Timeliness

In the course of our ongoing 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.

- *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, 2015.³³

³³VHA defines "backlogged" claims to be those that were received more than 30 days ago. 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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- *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.
 - *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 will help them 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 that we interviewed in the course of our ongoing 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. These 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, but 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.³⁴ According to VHA officials, the success of this long-term modernization plan will also hinge on significant investments in the development and deployment of new technology.

In its October 2015 strategic plan for consolidating VA care in the community programs and improving related business processes, 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 strategic plan, VHA will examine potential strategies for developing these capabilities in fiscal year 2016—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). The strategic plan states that

³⁴Department 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).

VHA will finalize more detailed implementation plans before the end of this fiscal year. The agency expects that deployment of its selected solutions will begin in fiscal year 2018 or later.

According to VHA, the efforts underway to address deficiencies in its claims processing system will present major challenges, such as revamping VHA's information technology systems and securing funding to do so. Our past work on planning best practices calls for an implementation strategy to help ensure that needed changes are made in a timely manner and that ramifications for key decisions (such as ones that relate to an agency's current and future workforce profile) are considered. To date, VHA has not developed a detailed plan for achieving these goals.

That VHA has not yet communicated a detailed plan is cause for concern, 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.³⁵ 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

³⁵See 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 *Veterans Health Care: VHA Has Taken Steps to Address Deficiencies in its Logistics Program, but Significant Concerns Remain*, [GAO-13-336](#) (Washington, D.C.: Apr. 17, 2013).

estimated to cost between \$300 million and \$400 million.³⁶ 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 revamp 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, in recent years 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.

In summary, our preliminary analyses show that 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. To its credit, VHA has recently implemented measures (including hiring more staff and purchasing new scanning equipment), which are intended to address some challenges that have impeded its claims processing timeliness. 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. These sweeping changes do not come without risk and cost, and VHA has struggled to make changes of a similar magnitude in the past. However—based on statements made by some of the community providers that participated in our review—without significantly improving the timeliness of its payments and 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 will risk losing the cooperation of

³⁶The 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.

these providers as it attempts to transition to a future care delivery model that would heavily rely on them to deliver care to veterans.

Because this work is ongoing, we are not making recommendations on VHA's processing and payment of claims from community providers at this time.

Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann, Assistant Director; Elizabeth Conklin; Krister Friday; Jacquelyn Hamilton; and Alexis C. MacDonald.

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