

August 2011

# VETERANS HEALTH CARE

## Monitoring Is Needed to Determine the Accuracy of Veteran Copayment Charges

U.S. Government Accountability Office



YEARS

1921-2011

ACCOUNTABILITY ★ INTEGRITY ★ RELIABILITY

## Why GAO Did This Study

In fiscal year 2010, the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) billed veterans millions of medical copayment charges totaling more than \$1 billion. Witnesses at a 2009 Subcommittee on Health, House Committee on Veterans' Affairs, hearing raised concerns about inappropriate copayment charges, including some associated with veterans' service-connected conditions. As a result, members of the Subcommittee asked GAO to review (1) VHA copayment charge accuracy, including error rates and related causes, and (2) VHA efforts to monitor copayment charge accuracy. To assess the accuracy of VHA's billed copayment charges, GAO evaluated samples of fiscal year 2010 billed and unbilled medical services to determine copayment error rates and related causes. GAO also reviewed VHA practices related to monitoring the accuracy of copayment charges.

## What GAO Recommends

GAO makes two recommendations to the Secretary of Veterans Affairs to (1) establish a copayment accuracy performance measure and (2) establish and implement a formal process for periodically assessing the accuracy of veteran copayment charges VHA-wide. In written comments on a draft of this report, VA agreed with GAO's recommendations.

## VETERANS HEALTH CARE

### Monitoring Is Needed to Determine the Accuracy of Veteran Copayment Charges

## What GAO Found

Of the more than 56 million fiscal year 2010 veteran copayment charges billed by VHA, GAO estimates, based on its test of a probability sample of copayment charges, that 96 percent (or approximately 54.2 million) of the copayment charges were accurate and 4 percent (or approximately 2.3 million) were inaccurate. GAO's tests of a separate probability sample of the approximately 519 million VHA medical services that did not result in copayment charges showed that each of those VHA determinations was accurate. These and other estimated percentages are based on test results of probability samples and are subject to sampling error. Appendix I of this report contains additional information on the samples and the 95 percent confidence intervals for the estimates contained in this report.

- Since the errors identified in GAO's probability sample all involved copayment overbilling, GAO estimates that 4 percent of the copayment charges involved overbilling of veterans. The errors GAO found were due to various factors, including inadequate review of previously billed copayment charges following retroactive changes in a veteran's service-connected conditions and the incorrect application of related medical reimbursements received from veterans' third-party insurance.
- In tests GAO performed on another probability sample to identify underbilling errors in the approximately 519 million medical services that did not result in copayment charges, GAO found that VHA correctly determined that each tested service should not have resulted in a copayment charge. As a result, GAO tests showed that VHA accurately did not bill copayment charges for these services, which made up more than 90 percent of the approximately 576 million medical services provided during fiscal year 2010.

While VHA performed various activities that involved reviewing the accuracy of some individual billed copayment charges, these activities do not constitute a systematic process for providing VHA-wide information on the accuracy and completeness of its copayment charges over time. In addition, GAO found that VHA had not established a performance measure for the accuracy level it wants to achieve in billing copayment charges. Without such a measure, it is not clear how the error rates GAO found would compare to error rates that VHA would consider acceptable, or if VHA would determine whether corrective actions need to be taken to reduce the error rates to lower levels. In addition, without a performance measure and periodic, systemwide information on the accuracy of its copayment charges, VHA cannot monitor changes in error rates and related causes over time. VHA also does not have meaningful performance information that it can provide to interested stakeholders when questions or concerns are raised concerning the accuracy of VHA's copayment charges billed to veterans.

---

# Contents

---

Letter		1
	Background	3
	Statistical Tests of VHA's Fiscal Year 2010 Copayment Charges Found That an Estimated 96 Percent Were Accurate	7
	VHA Does Not Monitor Its Systemwide Copayment Error Rate	12
	Conclusions	14
	Recommendations for Executive Action	15
	Agency Comments and Our Evaluation	15
Appendix I	Objectives, Scope, and Methodology	18
Appendix II	Enrollment in VA Health Care and Copayment Billing Process	25
Appendix III	Comments from the Department of Veterans Affairs	33
Appendix IV	GAO Contact and Staff Acknowledgments	36
Tables		
	Table 1: Fiscal Year 2010 VHA Medical Services	5
	Table 2: Number and Amount of Fiscal Year 2010 Copayment Charges by Type of Medical Service	6
	Table 3: Summary Information on Estimated Error Rates Related to VHA's Fiscal Year 2010 Billed Veteran Copayment Charges and Unbilled Medical Services	8
	Table 4: Fiscal Year 2010 Population of VHA Copayment Charges by Type	19
	Table 5: Causes for Identified Errors in Copayment Charges	20
	Table 6: Estimated Error Rates for Veterans' Fiscal Year 2010 Copayment Charges	21
	Table 7: Fiscal Year 2010 VHA Medical Services by Type	21
	Table 8: Estimated Rates Applicable to Fiscal Year 2010 Medical Services That Did Not Result in Veteran Copayment Charges	23
	Table 9: Causes for Observed Errors in Case Study Copayment Charges	24

---

Table 10: VA Health Care Enrollment Priority Groups and Their Eligibility Factors	27
Table 11: Fiscal Year 2010 VHA Veteran Medical Services	28
Table 12: General Applicability of Copayment Charges by Priority Group and Type of Service	30

---

### Abbreviations

CBI	Compliance and Business Integrity
CPAC	Consolidated Patient Account Center
CPRS	Computerized Patient Record System
HEC	Health Eligibility Center
MCCF	Medical Care Collections Fund
MQAS	Management Quality Assurance Service
POWER	Performance and Operations Web-Enabled Reports
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
VistA	Veterans Health Information Services and Technology Architecture

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



G A O

Accountability \* Integrity \* Reliability

United States Government Accountability Office  
Washington, DC 20548

---

August 29, 2011

### Congressional Requesters

The Department of Veterans Affairs (VA) provides health care to eligible veterans through 21 health care networks, each composed of multiple medical facilities, in the Veterans Health Administration (VHA). VHA is authorized by law to bill certain veterans for copayments for some medical services that are unrelated to conditions that VA has determined to be a result of their military service.<sup>1</sup> Medical services provided by VHA include inpatient and outpatient services, prescription medication, home health care, and extended care services, including nursing home and respite care. Representatives of veterans service organizations<sup>2</sup> testified at a congressional hearing<sup>3</sup> about their concerns that veterans were being billed for inappropriate copayment charges, including copayments billed for medical services linked to their service-connected conditions and injuries and multiple copayment charges billed for the same medical treatment. In light of these concerns, you asked us to review VHA's billing practices. This report addresses (1) the accuracy rate of VHA's copayment charges, including causes and rates of any over- and underbilling errors and (2) whether VHA had systems and processes in place to adequately monitor the accuracy of copayment charges billed to veterans.

In assessing the accuracy of VHA's fiscal year 2010 copayment charges (the most recent fiscal year for which the information was available), we first gained an understanding of VHA copayment billing practices by reviewing information on VHA's systems and processes related to determining which medical services should result in veteran copayment charges and then for billing applicable copayment charges. In conducting our work on copayment accuracy, including understanding VHA activities

---

<sup>1</sup> 38 U.S.C. §§ 1710, 1710B, and 1722A.

<sup>2</sup> Veterans service organizations advocate for veterans and assist them in obtaining benefits and medical care from VA. The organizations include AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars.

<sup>3</sup> *Identifying the Causes of Inappropriate Billing Practices by the U.S. Department of Veterans Affairs: Hearing on H.R. 3365 Before the H. Subcomm. on Health of the Comm. on Veterans' Affairs*, 111th Cong. (2009).

---

related to assessing the accuracy of copayment charges, we reviewed policies and procedures related to VHA's copayment billing process and veterans' eligibility for medical care and copayment billing. In addition, we performed a walk-through of the billing process at a VHA medical center and discussed billing and monitoring policies and practices with VHA officials and staff.

To determine the accuracy and completeness of VHA's copayment charges, including rates and causes of errors, we selected probability samples from two populations of VHA medical services provided to veterans—one from medical services that resulted in veteran copayment charges and the other from those medical services that did not result in copayment charges. For each sampled medical service, we reviewed relevant supporting documentation from VHA and from the Veterans Benefits Administration (VBA), which included information regarding the veterans' service-connected conditions. From this review, we determined whether a veteran should have been billed a copayment charge for the underlying medical service and, if so, whether the billed copayment charge amount was correct or, if not, whether the copayment charge was an over- or underbilling error. For each error identified, we determined the causes.<sup>4</sup> In addition, for three types of medical services—inpatient, extended care, and fee basis services—that were not selected in our sample because they infrequently result in copayment charges, we selected and tested three nongeneralizable probability samples of a limited number of copayment charges as case studies to gain some insight into the types and causes of any errors that we identified in copayment charges arising from these services. Finally, to determine whether VHA has systems and processes in place to adequately monitor the accuracy of billed veteran copayment charges, we obtained and reviewed available information on VHA practices related to monitoring the accuracy of billed veteran copayment charges.

---

<sup>4</sup> Our test of copayment charge accuracy included the accuracy of the original copayment charge billed to a veteran's account as well as VHA's handling of all subsequent adjustments to the copayment amount that occurred or should have occurred as a result of third-party insurance recovery related to the medical service or a retroactive adjustment or change to a veteran's service-connected conditions and applicable special authorities. Special authorities include care provided for disorders that may be associated with exposure to herbicide (including Agent Orange) or ionizing radiation, among other disorders. Copayments originally charged in error but then identified by VHA through a systematic review process and corrected in a timely manner are considered to be accurate.

---

We conducted this performance audit from February 2010 through August 2011 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.<sup>5</sup>

---

## Background

---

### VHA Health Care Eligibility and Enrollment

To obtain VHA health care, most veterans submit an application by mail or online to VHA's Health Eligibility Center (HEC) in Atlanta or in person at a local VHA medical center. Generally, the nature and extent of an individual veteran's service-connected medical conditions are established through VBA.<sup>6</sup> HEC processes applications and assigns veterans to one of eight priority groups based on their service-connected disabilities; special treatment authorities, such as exposure to Agent Orange or ionizing radiation; and income level. Whether VHA charges a veteran a copayment for medical services it provides is determined, in part, by the veteran's priority group. For example, veterans in priority group 1 are not required to pay any copayments, and veterans in priority groups 7 and 8 are generally required to pay copayments for all types of medical services. See appendix II for additional details on the enrollment and eligibility process, including priority groups and requirements for copayments.

When VHA is notified by VBA of a change in a veteran's service-connected conditions or disability rating, VHA is responsible for reevaluating the veteran's priority group status and reviewing the veteran's account to determine whether any copayment charges that

---

<sup>5</sup> See app. I for additional details on our scope and methodology.

<sup>6</sup> VBA determines veterans' service-connected conditions and degree of disability caused by those conditions. Once VBA has made these determinations, a veteran is entitled to file a claim for additional service-connected conditions or for a change in the degree of service-connected disability through a formal process known as adjudication. VBA automatically sends information regarding awarded service-connected conditions, including subsequent changes, to HEC for, among other things, HEC's use in determining a veteran's priority group status.

---

were assessed after the effective date of the VBA award should be canceled or refunded, if applicable, or whether any copayments should be charged.

---

## Medical Service and Copayment Billing

Veterans' health records are stored in the Computerized Patient Record System (CPRS) application of the Veterans Health Information Services and Technology Architecture (Vista) system. CPRS includes information on veterans' rated service-connected conditions and special treatment authorities. When a veteran receives a VHA-provided medical service, the provider identifies in CPRS whether the service provided was related to the veteran's service-connected conditions or provided under a special treatment authority.

When medical services provided to a veteran are not otherwise precluded from copayment billing, Vista automatically establishes a copayment charge to the veteran's account. Vista prevents copayment charges to a veteran when

- a provider indicates in CPRS that the medical service provided was related to a veteran's service-connected conditions or special authority;
- the medical service provided is one that is exempt from copayments for all veterans, such as preventive screenings, immunizations, and some laboratory services; and
- a veteran receives more than one medical service in a single day.<sup>7</sup>

If a veteran has third-party medical insurance, Vista puts the copayment charge placed on the veteran's account on hold for up to 90 days to allow time for VHA to process a claim for reimbursement from the third-party insurer. To the extent that VHA receives third-party reimbursement attributable to the medical service that resulted in a copayment being charged to a veteran's account, VHA's policy is to apply the insurance reimbursement to reduce or eliminate the related pending copayment charge. The third-party insurance offset process is a manual process that is to be performed, according to VHA policy, on a daily basis by local medical center staff.

---

<sup>7</sup> When a veteran receives more than one medical service in a day, only one copayment charge—the highest applicable amount—is charged to the veteran's account. This exception does not apply to multiple prescription services on the same day.



---

See appendix II for additional details on the copayment billing process.

---

## Fiscal Year 2010 Medical Services and Copayment Charges

According to fiscal year 2010 VA information, VHA provided approximately 576 million medical services to over 5.6 million veterans through VHA's 21 health care networks composed of 153 medical centers, 768 outpatient clinics, and 134 nursing homes located in all 50 states, the District of Columbia, and territories including Puerto Rico and the Virgin Islands. When VHA facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing the care or services required, VHA may authorize and pay a non-VHA provider to provide certain veterans hospital care and medical services. When authorized, VHA identified these as fee basis services. Table 1 shows the types, number, and percentage of medical services provided by type—outpatient, prescription, inpatient, extended care, and fee basis.

---

**Table 1: Fiscal Year 2010 VHA Medical Services**

Medical service type	Number of services (in thousands)	Percentage of services
Outpatient	407,858	70.83
Prescription	136,036	23.63
Inpatient	7,703	1.34
Extended care	707	0.12
Fee basis	23,494	4.08
<b>Total</b>	<b>575,798</b>	<b>100.00</b>

Source: GAO analysis of VHA data.

VA is also authorized, by statute to bill certain veterans for medical service copayments (38 U.S.C. § 1710, 1710B, 1722A), and, if applicable, their third-party medical insurance when the medical services VHA provides are not related to the veteran's service-connected medical conditions or associated with special treatment authorities (38 U.S.C. § 1729). These collections supplement VA's appropriations and are used to fund VHA medical services to veterans.

When VHA provides medical services that are not associated with a veteran's service-connected conditions or special treatment authorities and the veteran has third-party medical insurance, VHA is authorized by statute (38 U.S.C. § 1729) to pursue insurance reimbursement to the extent available under the veteran's coverage from the veteran's third-

party insurance. Veterans who owe copayment charges for medical services for non-service-connected conditions or for conditions not related to special treatment authorities must be allowed to benefit from their third-party insurance to satisfy their VHA obligations. Therefore, VHA is required to apply any insurance reimbursement it receives from a veteran's third-party insurance to the related copayment charge to reduce or eliminate the copayment charge owed by the veteran.

VHA billed veterans for over 56.5 million copayment charges totaling over \$1 billion in fiscal year 2010. These copayment charges were related to approximately 9.8 percent of the total of approximately 576 million VHA medical services provided. Individual veteran copayment amounts in fiscal year 2010 ranged from a low of \$5 for some extended care services to a high of \$1,100 for the first 90 days of an inpatient hospital stay. Most billed copayment charges (88 percent) were for prescription medications, for which the copayment charge is generally \$8 or \$9 for up to a 30-day supply of medication. Table 2 shows the number, amounts, and related percentages associated with the copayment charges billed to veterans in fiscal year 2010 by type of service.

**Table 2: Number and Amount of Fiscal Year 2010 Copayment Charges by Type of Medical Service**

Medical service type	Total number of copayment charges (in thousands)	Percentage of individual copayment charge types	Value of billed copayment charges (in thousands)	Percentage of billed copayment charge value
Prescription	49,852	88.22	\$824,504	78.02
Outpatient	6,325	11.19	173,698	16.44
Inpatient	125	0.22	47,255	4.47
Extended care	12	0.02	4,653	0.44
Fee basis	196	0.35	6,742	0.64
<b>Total</b>	<b>56,510</b>	<b>100.00</b>	<b>\$1,056,852</b>	<b>100.00</b>

Source: GAO analysis of VHA data.

Note: Percentages may not add to 100 because of rounding.

---

## Statistical Tests of VHA's Fiscal Year 2010 Copayment Charges Found That an Estimated 96 Percent Were Accurate

Based on our tests of a probability sample of billed copayment charges, we estimate that 96 percent of VHA's fiscal year 2010 copayment charges were accurate and 4 percent were inaccurate or erroneous.<sup>8</sup> We selected a probability sample of 100 fiscal year 2010 copayment charges billed to veterans, which included only prescription and outpatient services,<sup>9</sup> and found 4 erroneous copayment charges, each of which resulted in an overbilling to a veteran. Based on these test results, we estimate that of VHA's 56.5 million fiscal year 2010 copayment charges, approximately 54.2 million (96 percent) were accurate and approximately 2.3 million (4 percent) were inaccurate.<sup>10</sup> In addition, none of the four copayment errors we found involved underbilling of veterans.<sup>11</sup>

In fiscal year 2010, more than 90 percent of VHA's medical services did not result in billed copayment charges. To assess the completeness of the billed copayment charge population and the extent of possible underbilling errors associated with those medical services, we also selected a second probability sample of 100 unbilled medical services to assess whether VHA had correctly determined that each of the tested medical services should not have been billed. We did so because incorrect "no bill" determinations by VHA would represent underbilling inaccuracies associated with VHA's fiscal year 2010 copayment charges. Our tests of 100 unbilled medical services found that VHA correctly determined that each of the medical services should not have resulted in a veteran copayment charge—a 100 percent accuracy rate for this

---

<sup>8</sup> The estimated error rate in the population is based on observing errors in our probability sample of billed copayment charges. Because this estimate is based on a probability sample, it is subject to sampling error because a different probability sample could have produced different results. As a result, we are 95 percent confident that fiscal year 2010 charges were inaccurate between 1.1 and 9.9 percent of the time. See app. I for additional information on our sample and sampling errors.

<sup>9</sup> Because this probability sample was drawn from the population of billed copayment charges for which prescription (88.2 percent) and outpatient (11.2 percent) services made up over 99 percent of all copayment billed services, our probability sample of copayment charges included only prescription- and outpatient-related copayment charges.

<sup>10</sup> We are 95 percent confident that for fiscal year 2010, the number of accurate VHA copayment charges was between 50.9 million and 55.9 million and the number of inaccurate copayment charges was between 622,000 and 5.61 million. See app. I for additional information on our sample and sampling errors.

<sup>11</sup> We are 95 percent confident that for fiscal year 2010, the underbilling error rate for VHA's copayment charges was between 0 percent and 3 percent. App. I contains additional information on our sample of unbilled services.

probability sample. As a result, we are 95 percent confident that for fiscal year 2010, VHA's rate of error in the population of unbilled medical services associated with incorrectly determining that medical services should not have resulted in a copayment charge was between 0 percent and 3 percent.<sup>12</sup> (See table 3.)

**Table 3: Summary Information on Estimated Error Rates Related to VHA's Fiscal Year 2010 Billed Veteran Copayment Charges and Unbilled Medical Services**

Sampled population	Type of possible error	Number of errors	Estimated error rate percentage	Ninety-five percent confidence		Size of applicable population
				Lower limit percentage	Upper limit percentage	
Billed copayment charges	Copayment charge—overbilling	4	4	1.1	9.9	56.5 million copayment charges
Billed copayment charges	Copayment charge—underbilling	0	0	0	3	56.5 million copayment charges
Unbilled medical services	Failed to bill a valid copayment charge	0	0	0	3	519.3 million <sup>a</sup> unbilled medical services

Source: GAO test results from a VHA-wide probability sample of billed copayment charges to veterans and a second VHA-wide probability sample of unbilled medical services.

<sup>a</sup>Population is estimated using fiscal year 2010 medical services and copayment charges prepared in fiscal year 2010.

### Nature and Causes of Copayment Billing Errors Vary

With respect to erroneous copayment charges and our estimated error rate of 4 percent, we found that each of the four copayment errors occurred in overbilling to a veteran because

- the veteran was billed for an incorrect amount,
- the charge should have been reversed or offset, or
- if paid, the amount should have been refunded to the veteran.

Also, three of the four errors we found had not been identified by VHA prior to our selection of the copayment charges for testing. For the fourth error, VHA learned about the error when the veteran notified VHA after

<sup>12</sup> We are 95 percent confident that in fiscal year 2010, for the population of unbilled medical services, VHA correctly determined that medical services should not result in a copayment charge between 97 percent and 100 percent of the time. App. I contains additional information on our sample of unbilled services.

---

receiving a monthly statement containing the wrong copayment charge amount.

The four overbilling errors we found resulted from three causes. For one of the errors, the copayment should not have been billed to the veteran because, prior to billing the veteran, VHA had received sufficient third-party insurance reimbursement to offset the copayment and eliminate any amount owed by the veteran. Two of the errors involved copayment charges that were paid by the veterans but were not later refunded by VHA as would have been correct following VBA decisions that resulted in a retroactive change to the veterans' priority group status. VBA had informed VHA that it had retroactively awarded the veterans either an additional service-connected condition or increased a veteran's disability rating, which led VHA to change the two veterans' priority groups. With a (retroactive) change in priority group back to an effective date prior to the medical service that led to the copayment charge we tested, each of the veterans was no longer responsible for the copayment charge they had paid. Once VHA revised the veterans' priority group status in response to VBA's retroactive decisions, the veterans were due refunds for the two paid copayment charges we tested. VHA had been aware of VBA's retroactive award decisions for at least 4 months prior to our identification of the copayments as errors; however, VHA had not determined that the veterans were due refunds for the tested copayment charges. Following our test-related inquiries, VHA officials provided us with documentation that refunds to the veterans had been approved by VHA. The fourth copayment error resulted when VHA incorrectly billed a veteran a copayment amount for a 90-day prescription, instead of the smaller copayment amount that was due for the 30-day prescription supply the veteran received. After the veteran inquired about the erroneous charge, VHA corrected it on the veteran's subsequent monthly statement.

---

## Case Study Tests Found Copayment Errors

Three types of VHA medical services—inpatient, extended care, and fee basis services—together represented less than 1 percent of VHA's fiscal year 2010 copayment charge population.<sup>13</sup> Therefore, to provide some limited insight into copayments related to these infrequently billed services, we tested—as case studies—three small probability samples

---

<sup>13</sup> Because of the relatively high number of prescription and outpatient services in the population, the probability sample of 100 copayment charges we tested did not include any copayment charges resulting from these three types of medical services.

---

consisting of 10 each for inpatient, extended care, and fee basis services.<sup>14</sup>

We found four inaccurate copayment charges—two errors each associated with inpatient and extended care services. Three of the four copayment errors represented overbilling (two extended care services and one inpatient service) and the other represented an underbilling error (one inpatient service). In each case, VHA had not identified the copayment errors we found prior to our selecting the copayment charges for testing. Two of the three overbilling errors we found in our case study tests involved VHA's incorrect application of the veterans' third-party insurance reimbursement to offset the veterans' copayment charges. The third overbilling error occurred when VHA billed the veteran for a second copayment charge in the same day, which generally is not permitted under VHA's policy. The one underbilling error occurred when VHA incorrectly billed a veteran a lower copayment amount based on the 2009 copayment rate instead of the higher 2010 copayment rate that was applicable at the time medical service was provided.

Our case study test results are not generalizable to the larger populations of medical services from which the samples were drawn. However, they may provide some limited insight into copayment errors affecting these infrequently billed types of medical services. Copayment errors identified in both the probability sample and the case study test work mostly involved overbillings, including errors resulting from VHA's incorrect handling of third-party insurance reimbursements. The case study errors we found do not affect our estimate of VHA's overall error rate for fiscal year 2010 copayment charges.

VHA's processes for determining copayment charges for many of the copayments we tested resulting from inpatient, extended care, and fee basis services are more complicated and generally require greater VHA staff involvement and review compared with the processes for determining the copayment charges associated with the more routine outpatient and prescription services. This difference in complexity may help explain why we found four copayment errors—two each in two of the three small probability samples we tested in our case studies.

---

<sup>14</sup> Although the copayment charges we tested as part of our case study tests were randomly selected, they represent a nongeneralizable sample and were not designed to produce estimates or to be used to make inferences about their population.

---

## Veteran-Specific Data Issues Could Affect Other Copayment-Related Billing Decisions

In conducting our tests of the accuracy of VHA's copayment charges and "no bill" decisions,<sup>15</sup> we compared relevant veteran-specific data maintained by VBA and VHA's HEC and local medical centers to determine whether the VHA data were consistent and correct. The relevant data we compared included each veteran's recorded service-connected conditions, degree of disability, and priority group status.<sup>16</sup> These data are key to correctly determining whether a medical service should be billed to a veteran as a copayment charge and, if so, the correct amount of the copayment. Of the 200 medical services we tested, we found that the key data for 197 veterans were consistently and correctly recorded by VBA and VHA's HEC and local medical centers. We found two instances where specific elements of veteran data were not consistently recorded in VHA records and one instance in which the recorded data were incorrect. After following up with VHA on these instances, VHA corrected the data. While these data recording errors did not cause the particular copayment-related charge or "no bill" decision we tested to be inaccurate, they could have affected other VHA copayment-related decisions for these veterans.

In one of the two data inconsistencies we found, HEC and the local VHA medical center's records had the veteran's combined service-connected condition percentage lower than what VBA had established, which resulted in the veteran being assigned to an incorrect priority group. As a result, if the veteran had been provided certain other medical services, the data inconsistency could have caused the veteran to be incorrectly charged a copayment. VHA officials said that the cause for the incorrect data related to the data transfer from VBA to VHA's HEC and local medical centers. According to VHA, the data transfer issue and the incorrect data have since been corrected. In the other data inconsistency instance, the disability rating recorded in HEC's and the medical center's records were inconsistent, resulting in the medical center having the veteran in an incorrect priority group. According to VHA, the data error was due to problems during registration at the medical center, which have since been resolved. The third data error involved a local medical center's

---

<sup>15</sup> For the probability samples we tested for the accuracy of VHA's billed copayment charges and VHA's decisions that other medical services should not result in a copayment charge, we obtained and reviewed VBA and VHA data for 200 veterans—100 for each of the two samples.

<sup>16</sup> For priority group status, we compared data from HEC and the medical centers, as they maintain data on a veteran's assigned priority group status.

---

records having an incorrect priority group for a veteran. The medical center had not received the information needed to update the veteran's financial assessment (also known as a means test), which was necessary to keep the veteran in a priority group that would have made him exempt from paying certain copayments. After our follow-up inquiries, VHA confirmed that at the time the medical service was provided, the veteran's recorded priority group was incorrect, and the center has since received the information necessary to update the financial assessment, and the veteran's recorded priority group is now correct.

---

## VHA Does Not Monitor Its Systemwide Copayment Error Rates

While various activities performed by VHA staff involve examining or reviewing the accuracy of some individual veteran copayment charges, we found that those activities do not provide VHA with systematic VHA-wide information on the accuracy of copayment charges needed to effectively monitor—over time—the rates of and causes for copayment errors. We also found that VHA has not established a performance measure or goal for the level of accuracy it wants to achieve for the copayment charges it bills to veterans. As a result, it was not clear how the copayment charge error rates we observed in our probability samples would compare to rates of error VHA would consider acceptable or whether corrective action needs to be taken to reduce the error rates to lower levels. In addition, without procedures to periodically assess the accuracy and completeness of its copayment charges, VHA does not have the information needed to determine whether changes in its accuracy rates are occurring over time.

In reviewing VHA's copayment billing process and the extent to which VHA systematically monitors its copayment charges for accuracy, we identified various activities that generally involved reviewing or checking the accuracy of some individual copayment charges; however, those activities are performed for reasons other than a systematic VHA-wide assessment of the accuracy of billed copayment charges and do not provide sufficient information for systemwide monitoring.

- **Responding to veteran inquiries.** VHA responds to veteran-related questions or inquiries concerning specific copayment charges. In doing so, VHA may evaluate some individual copayment charges and determine whether they were accurate. However, VHA does not systematically track and analyze the results of these individual reviews, including whether the copayment charges were accurate or inaccurate and, if applicable, the cause of any inaccuracies.



- 
- **Revenue reviews.** Staff from VA's Management Quality Assurance Service's (MQAS) Health Care Financial Assurance Division may evaluate specific veteran copayment bills on a limited, ad hoc basis as part of the recurring reviews of VA revenue activities at selected individual medical centers. During these reviews, MQAS officials said they devote most of their resources to evaluating third-party insurance collections, as they make up the majority of the Medical Care Collections Fund (MCCF).<sup>17</sup> These revenue reviews are focused on third-party insurance recoveries and in only some instances may involve reviewing the accuracy of individual veteran copayment charges.
  - **Local compliance programs.** Individual medical centers and Consolidated Patient Account Centers (CPAC) have decentralized compliance programs that include varied processes and procedures related to reviewing some individual copayment charges. The scope and results of these compliance reviews may involve reviewing copayment-related charges but do not routinely include a systematic assessment of a probability sample of copayment charge accuracy. In addition, the results of any reviews of copayment charge accuracy at medical centers and CPAC locations are not consolidated and reported to VHA management.
  - **Targeted reviews of certain copayment charges.** VHA instituted a policy in October 2006,<sup>18</sup> in response to a VA Inspector General report,<sup>19</sup> requiring VHA's Compliance and Business Integrity (CBI) Office to identify delinquent copayment debts for certain veterans whose accounts were being referred to debt collection. VHA facilities were required to review the accounts to help ensure that the referrals were not based on inaccurate copayment charges. Initially, the policy required the VHA facilities to report to the CBI Office the results of their targeted reviews until the error rate in the applicable copayment charges went below 10 percent for two consecutive quarters. As a result of a sustained decrease in the related billing error rate, in October 2009, the CBI Office stopped collecting national monitoring

---

<sup>17</sup> Collections from copayments, third-party reimbursements, parking fees, and other fees are deposited in the MCCF and expended at the local medical centers as medical service funds.

<sup>18</sup> VHA, *First Party Co-Payment Monitoring Policy*, VHA Handbook 1030.03 (Oct. 16, 2006).

<sup>19</sup> VA, Office of Inspector General, *Evaluation of Selected Medical Care Collections Fund First Party Billings and Collections*, Rep. No. 03-00940-38 (Dec. 1, 2004).

---

results from VHA facilities, and in March 2010, VHA rescinded the requirements for facilities to report the results of their quarterly reviews to the CBI Office.<sup>20</sup> However, VHA facilities are still responsible for conducting the reviews.

As noted, these activities are conducted for specific reasons and are not intended to provide VHA with systematic VHA-wide information on the accuracy and completeness of copayment charges needed to effectively monitor—over time—the rates of and causes for copayment errors. Also, having meaningful performance information to provide to stakeholders, including veterans organizations and Congress, could be useful in cases where questions regarding the accuracy and completeness of copayment charges are raised.

---

## Conclusions

Our tests of a probability sample of VHA copayment charges found copayment errors which we estimate to be 4 percent or approximately 2.3 million of VHA's 56.5 million fiscal year 2010 copayment charges. However, because VHA does not have established acceptable or tolerable error rates for copayment charges, the extent to which the error rates we observed would compare to levels of performance that VHA would consider acceptable is unclear. We believe that it is important for VHA to establish a performance measure for the copayment accuracy rate it wants to achieve in billing copayment charges to veterans and, once it is established, to periodically assess—on a systematic basis—the accuracy and completeness of its copayment charges. With such information, VHA would be able to make informed decisions concerning the rates and causes of erroneous copayment charges, including whether any actions are needed to lower its overall error rate. Such periodic assessments could be integrated into VHA's existing quality assurance monitoring efforts and provide meaningful management information on various aspects of its copayment billing systems and processes, including whether key veteran data were consistently and correctly recorded in VHA records and systems. Further, having meaningful performance information regarding copayment accuracy to provide to stakeholders, including veterans organizations and Congress, could assist VA in responding to any questions concerning the accuracy and completeness of copayment charges.

---

<sup>20</sup> VHA Notice 2010-03, *Rescission of VHA Handbook 1030.03, First-Party Co-Payment Monitoring Policy* (Mar. 4, 2010)

---

## Recommendations for Executive Action

To provide VHA with the information needed to adequately monitor the accuracy of copayment charges VHA-wide and to assess and respond to the causes of copayment errors, the Secretary of Veterans Affairs should direct VHA to take the following two actions:

- establish an accuracy performance measure or goal for copayment charges billed to veterans and
- establish and implement a formal process for periodically assessing—VHA-wide—the accuracy of veteran copayment charges and taking corrective actions as necessary.

---

## Agency Comments and Our Evaluation

In its written comments, VA generally agreed with our conclusions and agreed with our recommendations. It also provided an overview of planned actions, starting in fiscal year 2012, including plans to establish an initial national performance measure for copayment charge accuracy and implement a periodic assessment of billed copayment accuracy. As VA implements these plans, it will be important for these actions to provide the information needed to monitor VHA-wide copayment accuracy and completeness and to assess and respond to the causes of copayment errors. Such plans, if fully and effectively implemented in accord with our conclusions and recommendations, should respond to the conditions we found. We also incorporated VA's technical comments where appropriate. VA's comments are reprinted in appendix III.

---

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Veterans Affairs, appropriate congressional committees, and other interested parties. The report will also be available at no charge on the GAO website at <http://www.gao.gov>.

---

If you or your staffs have any questions about this report, please contact me at (202) 512-9095 or [raglands@gao.gov](mailto:raglands@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix IV.



Susan Ragland  
Director, Financial Management and Assurance

---

*List of Requesters*

The Honorable Michael H. Michaud  
Ranking Member  
Subcommittee on Health  
Committee on Veterans Affairs  
House of Representatives

The Honorable Gus M. Bilirakis  
House of Representatives

The Honorable Corrine Brown  
House of Representatives

The Honorable Vern Buchanan  
House of Representatives

The Honorable Jerry McNerney  
House of Representatives

The Honorable Cliff Stearns  
House of Representatives

---

# Appendix I: Objectives, Scope, and Methodology

---

Pursuant to a request from members of the Subcommittee on Health, House Committee on Veterans' Affairs, we reviewed the Veterans Health Administration's (VHA) copayment billing practices to determine (1) the accuracy rate for VHA copayment charges, including causes for any under- and overbilling errors, and (2) whether VHA had systems and processes in place to adequately monitor the accuracy of copayment charges billed to veterans.

---

## Assessment of VHA Copayment Charge Accuracy

To determine the accuracy rate and any causes for under- and overbilling errors, we used as our criteria applicable law and VHA policy. To gain an understanding of VHA's policies, procedures, systems, and processes related to copayment billing practices, we performed walk-throughs of applicable processes with appropriate VHA staff at a medical center. We reviewed and discussed with agency officials and staff applicable processes related to VHA's copayment billing practices. We also interviewed Veterans Benefits Administration (VBA) officials and staff about VBA decisions related to veterans' service-connected conditions and disability ratings and the transfer of that information to VHA. In addition, to assess the reliability of data and information used in this report, we reviewed Department of Veterans Affairs' (VA) procedures for ensuring the reliability of data and information generated by key VHA systems used in the copayment billing process, including VHA's Veterans Health Information Systems and Technology Architecture (VistA), Performance and Operations Web-Enabled Reports (POWER), and Prescription Benefits Management systems. We determined that the data and information generated from key VHA systems used in the copayment billing process were sufficiently reliable for the purposes of our testing.

---

## Probability Sample of VHA Copayment Charges

To determine the accuracy of the copayment amount billed to veterans, we selected a simple probability sample of 100 copayment charges from the population of approximately 56.5 million fiscal year 2010 copayment charges in POWER.<sup>1</sup> This sample was designed to estimate the error rates in the population, if errors were found in the sample, or to conclude with 95 percent confidence that the population error rate is less than 3 percent, if no errors were found in the sample. The population consisted

---

<sup>1</sup> With this probability sample, each member of the study population had a nonzero probability of being included, and that probability could be computed for any member.

of five broad types: (1) prescription, (2) outpatient, (3) inpatient, (4) extended care, and (5) fee basis (see table 4).

**Table 4: Fiscal Year 2010 Population of VHA Copayment Charges by Type**

Type of charge	Number of charges in population	Number of charges as percentage of total
Prescription	49,851,878	88.22
Outpatient	6,324,632	11.19
Inpatient	125,250	0.22
Extended care	11,938	0.02
Fee basis	196,340	0.35
<b>Total</b>	<b>56,510,038</b>	<b>100.00</b>

Source: GAO analysis of VHA data.

To assess the reliability of population data used to select the sample, we (1) reviewed related documentation, (2) reviewed internal and external reports related to the systems, and (3) interviewed knowledgeable VHA officials. We also, as part of our testing of unbilled medical services, determined that for the purposes of our testing, the population of fiscal year 2010 copayment charges was materially complete. Based on our data reliability analysis, we determined that the population data, obtained from POWER, were sufficiently reliable for the purposes of our testing. For each sampled item, we obtained applicable information and supporting documentation from VHA and VBA and determined whether a veteran's copayment charge was accurate in accordance with VHA's established policies, procedures, systems, and guidance. For each inaccurate copayment charge, we determined the cause and provided VHA with an explanation of the error, the related cause, and any other relevant information. Table 5 contains a detailed breakout of the causes of the errors in copayment charges.<sup>2</sup>

<sup>2</sup> Our test of copayment charge accuracy included the accuracy of the original copayment charge billed to a veteran's account as well as VHA's handling of all subsequent adjustments to the copayment amount that occurred or should have occurred as a result of third-party insurance recovery related to the medical service or a retroactive adjustment or change to a veteran's service-connected conditions and applicable special authorities. Copayments originally charged in error, but then identified by VHA through a systematic review process and corrected in a timely manner, are considered to be accurate.

**Table 5: Causes for Identified Errors in Copayment Charges**

<b>Causes of identified errors</b>	<b>Number of errors</b>
Incorrect application of third-party insurance offset	1
Unprocessed refund following retroactive adjudication	2
Incorrect charge amount	1
<b>Total</b>	<b>4</b>

Source: GAO analysis.

There were limitations because of the nature of the testing we performed. We did not

- test the medical determinations (i.e., diagnosis and whether the service was related to a veteran’s service-connected conditions or special treatment authority) of the medical service provider (including the pharmacist, doctor, nurse, or other medical staff);
- test the determinations made as a result of the adjudication process at VBA to determine the veteran’s service-connected conditions and related disability rating percentages;
- test the determination made by VHA on whether to bill a third-party insurer for the medical service or the third-party insurer’s determination to pay, including the amount of that payment; and
- confirm through outside sources (including contacting applicable veterans) the accuracy or completeness of veteran-specific information relied on by VHA as part of its decision to bill tested copayment charges.

In table 6, we present our statistical results as (1) our projection of the estimated error overall and (2) the 95 percent, two-sided confidence intervals for the projections.<sup>3</sup>

<sup>3</sup> Our 95 percent confidence interval means that if you were to determine an estimate for 100 different probability samples, 95 out of 100 times the confidence interval would include the actual population value. In other words, the actual population value is between the lower and upper limits of the confidence interval 95 percent of the time.



**Table 6: Estimated Error Rates for Veterans' Fiscal Year 2010 Copayment Charges**

Test results	VHA-wide accuracy rate	VHA-wide error rate
Percentage estimate	96%	4%
Ninety-five percent, two-sided confidence interval	90.1% - 98.9%	1.1% - 9.9%
Estimated copayment charges in fiscal year 2010 (two-sided)	50.9 million – 55.9 million	622,000 – 5.61 million

Source: GAO analysis.

**Probability Sample of Unbilled Medical Services**

To (1) assess the completeness of the population of fiscal year 2010 copayment charges billed to veterans and (2) determine the accuracy of VHA's decisions not to bill veterans copayments for medical services provided in fiscal year 2010, we selected for review a probability sample of 100 unbilled medical services from the population of VHA's approximately 576 million fiscal year 2010 medical services.

Our sampling frame for this sample was developed by combining databases from three VHA data warehouses (the National Patient Care database, Purchased Care Data warehouse, and Pharmacy Data warehouse), which totaled approximately 576 million medical services provided in fiscal year 2010. VHA's databases do not separately identify or track unbilled services, so this set of databases contained both billed and unbilled fiscal year 2010 medical services. The population of medical services consisted of five broad types: (1) prescription, (2) outpatient, (3) inpatient, (4) extended care, and (5) fee basis (see table 7).

**Table 7: Fiscal Year 2010 VHA Medical Services by Type**

Medical service	Number of services	Percentage of services
Outpatient	407,857,973	70.83
Prescription	136,035,517	23.63
Inpatient	7,702,514	1.34
Extended care	707,388	0.12
Fee basis	23,494,198	4.08
<b>Total</b>	<b>575,797,590</b>	<b>100.00</b>

Source: GAO analysis of VHA data.

Because the VHA-provided population of all medical services from which we selected our sample included services that resulted in copayment charges, we initially selected a larger probability sample of 150 medical services. After checking billing records, we excluded any sampled

medical services that resulted in a copayment charge. From the remaining medical services, we selected the first 100 as our probability sample of unbilled medical services.

This sample was designed to test for a 3 percent tolerable error rate so that if we found no billing errors in the sample, we would be able to conclude with 95 percent confidence that (1) the population of fiscal year 2010 unbilled medical services did not include a material number (more than 3 percent) of medical services that should have been billed as copayment charges and (2) the population of billed fiscal year 2010 copayment charges was materially complete for the purposes of our tests. If errors were found, this sample could be used to estimate the rate of copayment underbilling errors associated with incorrect VHA determinations not to bill medical services in this population.

To assess the reliability of population data used to select this sample for testing, we (1) reviewed related documentation, (2) reviewed any internal or external reports related to the systems, and (3) interviewed knowledgeable VHA officials. Based on our data reliability analysis, we determined that the population data were sufficiently reliable for the purposes of our testing. For each of the unbilled medical services we tested, we obtained applicable information and supporting documentation from VHA and VBA to determine whether VHA correctly determined that the 100 tested fiscal year 2010 medical services should not have resulted in copayment charges, in accordance with VHA's established policies, procedures, systems, and guidance.

There were limitations because of the nature of the testing we performed. We did not

- test the medical determinations (i.e., diagnosis and whether the service was related to a veteran's service-connected conditions or special treatment authority) of the medical service provider (including the pharmacist, doctor, nurse, or other medical staff);
- test the determinations made as a result of the adjudication process at VBA to determine the veteran's service-connected conditions and related disability rating percentages;
- test VHA's ability to record all of the medical services in the medical center-level VistA system, or VHA's ability to transfer all the medical services to the appropriate data warehouse; and
- confirm through outside sources (including contacting applicable veterans) the accuracy or completeness of veteran-specific

information relied on by VHA as part of its decision to not bill for tested medical services.

In table 8, we present our statistical results as (1) our projection of the estimated error overall and (2) the 95 percent, two-sided confidence intervals for the projections.

**Table 8: Estimated Rates Applicable to Fiscal Year 2010 Medical Services That Did Not Result in Veteran Copayment Charges**

Test results	VHA-wide accuracy rate	VHA-wide error rate
Percentage estimate	100%	0%
Ninety-five percent, two-sided confidence interval	97% - 100%	0% - 3%
Estimated medical services in fiscal 2010 (two-sided) <sup>a</sup>	503.7 million – 519.3 million	0 – 15.6 million

Source: GAO analysis.

<sup>a</sup> Population is estimated using fiscal year 2010 medical services and copayment charges prepared in fiscal year 2010.

## Case Studies of VHA Copayment Charges

In addition to our statistical samples of copayment charges and unbilled medical services, we tested—as case studies—three small, nongeneralizable samples consisting of 10 copayment charges each from inpatient, extended care, and fee basis services.<sup>4</sup> These three types of medical services combined represented less than 1 percent of the VHA-wide fiscal year 2010 copayment population. Results from our nongeneralizable case study samples cannot be used to make inferences about any population; consequently, results obtained from these cases are specific to the particular cases selected. We conducted this testing to provide limited insight into possible errors in copayments billed for these types of medical services. For each case study, we obtained applicable information and supporting documentation from VHA and VBA and determined whether a veteran’s copayment charge was accurate in accordance with VHA’s established policies, procedures, systems, and guidance. For each inaccurate case study copayment charge, we determined the cause and provided VHA with an explanation of the error,

<sup>4</sup> Although these cases were randomly selected, we do not generalize to a larger population because of the small number of cases selected in each of the three samples.

the related cause, and any other relevant information. Table 9 contains a breakout of the results of the testing of the case studies.

**Table 9: Causes for Observed Errors in Case Study Copayment Charges**

Causes for observed errors	Inpatient	Extended care	Fee basis	Total
Incorrect application of third-party insurance offset	1	1	0	2
Incorrect charge amount error	1	0	0	1
Invalid copayment charge	0	1	0	1
<b>Total</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>4</b>

Source: GAO analysis.

## VHA Monitoring of Copayment Accuracy

To determine whether VHA had systems and processes in place to adequately monitor the accuracy of copayment charges, we identified relevant policies, procedures, systems, practices, and related documentation, whether at a national, regional, or local level, related to VHA's efforts to monitor copayment accuracy. We reviewed the documentation provided to determine whether it contributed to VHA periodically assessing the accuracy of copayment charges and taking appropriate action to address the underlying causes when errors or inaccuracies are found. We also interviewed knowledgeable staff and officials from VHA and VA's Office of Inspector General.

We conducted this performance audit from February 2010 through August 2011 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.

---

# Appendix II: Enrollment in VA Health Care and Copayment Billing Process

---

As part of our review of the accuracy of Veterans Health Administration (VHA) copayment charges, we gained an understanding of key aspects of veteran eligibility and enrollment for veteran health services, veteran medical services and related copayment charges, and copayment billing and adjustments.

---

## Veteran Eligibility and Enrollment

Veterans are eligible for Department of Veterans Affairs (VA) health care benefits based on their period of and separation from military service under any condition other than a dishonorable separation. To obtain VHA medical services, most veterans must take action to enroll in the VHA health care system. To initiate their enrollment, veterans submit a completed enrollment application (VA Form 10-10EZ) either by mail or online to VHA's Health Eligibility Center (HEC) in Atlanta for review and processing, or veterans may visit a local VHA medical center or facility where they can receive assistance in completing the enrollment form.

HEC establishes a veteran's enrollment status (priority group), which is primarily affected by decisions made by the Veterans Benefits Administration (VBA), which establishes and administers a variety of nonhealth benefits and services for veterans. VBA is responsible for determining a veteran's service-connected conditions and, to the extent applicable, a veteran's disability rating. In doing so, VBA adjudicates veteran claims by determining whether a veteran's illness or injury was incurred in or aggravated by the veteran's military service (i.e., a service-connected condition). Once awarded to a veteran, a service-connected condition is considered a "rated" service-connected condition. Additional service-connected conditions may also result in a change to a veteran's disability rating. VBA sends the veteran a notification letter informing him or her of the award decision, including the additional service-connected condition, applicable changes in disability rating, and the effective date of the award determination. Information on VBA award decisions is also automatically transmitted to HEC. VBA may grant additional service-connected conditions and change disability ratings retroactively by establishing an effective date that precedes the date VBA makes the determination.

Based on a veteran's service, including rated service-connected conditions, applicable disability rating, special treatment authorities, and other enrollment information such as the results of a financial assessment (called a means test), HEC assigns veterans to one of eight enrollment priority groups. Special treatment authorities include care provided pursuant to 38 U.S.C. § 1710(e), and implementing regulations at 38

C.F.R. §§ 17.36 (a)(3) and 17.36 (b)(6), which authorizes treatment for disorders that may be associated with a Vietnam-era veteran's exposure to herbicide (including Agent Orange); certain diseases deemed to be related to exposure to radiation; disorders that may be related to service in the Southwest Asia theater of operation during the Persian Gulf War; illnesses that may be related to services in a qualifying combat theater; and disorders that may be related to participation in certain biological and chemical warfare testing, including Project SHAD (Shipboard Hazard and Defense Project). Veterans covered by section 1710(e) are enrolled in priority group 6. Generally speaking, the more service-connected conditions, higher disability rating, and special treatment authorities that apply to a veteran, the less likely a veteran will be subject to copayment charges. Table 10 shows the eight priority groups and their eligibility factors.

**Appendix II: Enrollment in VA Health Care and Copayment Billing Process**

**Table 10: VA Health Care Enrollment Priority Groups and Their Eligibility Factors**

<b>Priority group</b>	<b>Eligibility factors</b>
1	<ul style="list-style-type: none"> <li>• Veterans with service-connected disabilities rated 50 percent or more disabling</li> <li>• Veterans determined by VA to be unemployable because of service-connected conditions</li> </ul>
2	<ul style="list-style-type: none"> <li>• Veterans with service-connected disabilities rated 30 percent or 40 percent disabling</li> </ul>
3	<ul style="list-style-type: none"> <li>• Veterans who are former prisoners of war</li> <li>• Veterans awarded the Purple Heart</li> <li>• Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty</li> <li>• Veterans with service-connected disabilities rated 10 percent or 20 percent disabling</li> <li>• Veterans awarded special eligibility classification under 38 U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"</li> <li>• Veterans awarded the Medal of Honor</li> </ul>
4	<ul style="list-style-type: none"> <li>• Veterans who are receiving aid and attendance or housebound benefits</li> <li>• Veterans who have been determined by VA to be catastrophically disabled</li> </ul>
5	<ul style="list-style-type: none"> <li>• Non-service-connected veterans and noncompensable service-connected veterans rated 0 percent disabled whose annual incomes, net worth, or both are below the established VA means test thresholds</li> <li>• Veterans receiving VA pension benefits</li> <li>• Veterans eligible for Medicaid benefits</li> </ul>
6	<ul style="list-style-type: none"> <li>• World War I veterans</li> <li>• Compensable 0 percent service-connected veterans</li> <li>• Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki</li> <li>• Project 112/SHAD participants (Shipboard Hazard and Defense Project)</li> <li>• Veterans exposed to the defoliant Agent Orange while serving in the Republic of Vietnam from 1962 through 1975</li> <li>• Veterans of the Persian Gulf War who served from August 2, 1990 through November 11, 1998</li> <li>• Veterans who served in a theater of combat operations after November 11, 1998, as follows:               <ul style="list-style-type: none"> <li>○ Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 23, 2003, are eligible for the enhanced benefits for 5 years post discharge</li> <li>○ Veterans discharged from active duty before January 23, 2003, who apply for enrollment on or after January 28, 2008, are eligible for this enhanced enrollment benefit through January 27, 2011</li> </ul> </li> </ul>
7	Veterans with income above the VA national income threshold and below the geographic income threshold who agree to pay copayment charges
8	Veterans with income above the VA national income threshold and the geographic income threshold who agree to pay copayment charges

Source: VHA.

## Medical Services and Copayment Charges

Medical services provided by VHA include inpatient and outpatient services, prescription medication, and extended services. When VHA facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing the care or services required, VHA may authorize and pay a non-VHA provider to provide certain veterans hospital care and medical services. When authorized, VHA identifies these as fee basis services.

VHA's clinical and health records system—the Computerized Patient Record System—contains, among other things, information on veterans' rated service-connected conditions and special treatment authorities. When a veteran receives medical services, the provider indicates in the system whether the service provided was related to a veteran's service-connected conditions or special authorities, which affects whether a copayment will be charged to the veteran.

According to VHA, almost 95 percent of the approximately 576 million medical services provided to veterans in fiscal year 2010 consisted of outpatient services (70.8 percent) and prescription services (23.6 percent). (See table 11.)

**Table 11: Fiscal Year 2010 VHA Veteran Medical Services**

Medical service type	Number of services (in thousands)	Percentage of services
Outpatient	407,858	70.83
Prescription	136,036	23.63
Inpatient	7,703	1.34
Extended care	707	0.12
Fee basis	23,494	4.08
<b>Total</b>	<b>575,798</b>	<b>100.00</b>

Source: GAO analysis of VHA data.

**Outpatient services.** There are three copayment tiers or categories that apply to outpatient services—no copayment, basic \$15 copayment, and specialty \$50 copayment. For example, an outpatient visit for immunizations or preventive screenings is included in the no copayment tier. A basic (nonspecialty) outpatient service, which includes primary care visits for diagnosis and management of acute and chronic conditions, has a \$15 copayment. A specialty outpatient service, which requires a referral, includes cardiology services and radiology services, such as magnetic resonance imagery, has a \$50 copayment. If the



medical service, which might otherwise have an applicable copayment, is determined to be related to a veteran's service-connected condition or special treatment authority, then no copayment charge would be due. Generally, only veterans in priority groups 7 and 8 are charged for applicable outpatient copayments. Further, when a veteran in priority group 7 or 8 receives more than one outpatient service in a single day, only one copayment—the highest applicable amount—is to be charged to the veteran for that day.

**Prescription services.** Veterans can fill prescriptions for medications at a VHA pharmacy or through the mail. Veterans whose prescriptions require a copayment are charged either \$8 (for veterans in priority groups 2 through 6) or \$9 (for priority groups 7 and 8)<sup>1</sup> for supplies of 30 days or less. If authorized, prescriptions may be filled for up to a 90-day period at a time with a corresponding copayment charge based on a longer number of days. Priority group 1 veterans do not pay any prescription copayment charges. Veterans in priority groups 2 through 6 are subject to applicable copayment charges but have an annual cap that limits their total prescription copayment charges to \$960 per year. Priority group 7 and 8 veterans are generally subject to applicable prescription copayments but do not have an annual cap.

**Inpatient services.** Inpatient stay copayment charges are \$1,100 for up to the first 90 days of care during a 365-day period and \$550 for each additional 90 days. In addition to the inpatient stay copayment charges, patients are also subject to inpatient per diem charges of \$10 per day. As with other medical services, no inpatient copayment or per diem will be charged if the stay is related to the veteran's service-connected conditions or special treatment authority. Generally, only veterans in priority groups 7 and 8 are charged applicable inpatient copayment and per diem charges.

**Extended care services.** Extended care services generally include both institutional (inpatient) and noninstitutional (outpatient) services. VHA does not charge any copayments for the first 21 days of extended care services in any 12-month period. Extended care copayment charges are capped at a maximum of \$97 per day for institutional nursing home or institutional respite care, \$5 per day for institutional domiciliary care, and

---

<sup>1</sup> The \$9 prescription copayment for priority groups 7 and 8 became effective July 1, 2010.

\$15 per day for noninstitutional adult day health care and noninstitutional respite care services. No extended care copayments will be charged if the services are related to a veteran's service-connected conditions or special treatment authorities. Generally, only veterans in priority groups 4 through 8 may be subject to extended care copayment charges.

**Fee basis care services.** VHA may authorize certain veterans to receive hospital care and medical services from non-VHA providers. When this occurs, VHA refers to these services as fee basis care. Non-VHA providers submit bills to VHA for medical services provided to veterans. Copayment amounts and requirements related to fee basis services are otherwise the same as those for services provided in VHA facilities.

Determining the correct applicable copayment charge depends on many factors, including the underlying medical service provided, a veteran's applicable service-connected conditions and special treatment authorities, priority group, and established copayment amount. Table 12 provides general information on whether copayment charges may apply to veterans in particular priority groups.

**Table 12: General Applicability of Copayment Charges by Priority Group and Type of Service**

Priority groups	Type of medical service			
	Outpatient <sup>a</sup>	Prescription <sup>b</sup>	Inpatient <sup>c</sup>	Extended care <sup>d</sup>
1	No	No	No	No
2 and 3	No	Yes	No	No
4	No	No	No	Yes
5	No	Yes	No	Yes
6	Yes	Yes	Yes	Yes
7	Yes	Yes	Yes	Yes
8	Yes	Yes	Yes	Yes

Source: GAO analysis of VHA data.

<sup>a</sup>No copayment is due for X-rays, lab tests, and immunizations; a \$15 copayment is due for primary outpatient care; and \$50 copayment is due for specialty outpatient care.

<sup>b</sup>An \$8 copayment is due for a 30-day prescription supply for veterans in priority groups 2 through 6 who are also subject to a calendar year cap of \$960; a \$9 copayment is due for a 30-day prescription supply for veterans in priority groups 7 through 8 who are not subject to the annual cap. (Priority groups 7 and 8 were subject to the \$8 copayment until July 1, 2010, when the \$9 amount became effective.)

<sup>c</sup>Veterans in priority groups 6 through 8 may be subject to a \$10 per diem charge and \$1,100 copayment charge for the first 90 days of an inpatient stay during a year and \$550 for each additional 90 days.

---

<sup>d</sup>Veterans in priority groups 4 through 8 are subject to applicable copayment charges of \$5 per day for domiciliary care, \$15 per day for noninstitutional respite care and adult day health care, and a maximum \$97 per day for institutional nursing home and respite care.

While table 12 reflects the general applicability of copayment charges by priority group, some exceptions apply, including the following:

- Former prisoners of war, who make up part of priority group 3, are not subject to any prescription copayment charges.
- Copayment requirements do not apply to priority group 6 veterans if medical service is related to the priority group 6 placement.
- For priority group 7 veterans, the inpatient stay copayment rate (\$1,100) is reduced by 80 percent.
- Veterans may be exempted from copayments based on results of the financial assessment.
- Veterans who experience temporary financial difficulties may apply to their local VHA facility for hardship waivers to eliminate copayments for a defined short-term period or to have VHA waive a specified amount of outstanding debt incurred for prior medical services.

---

## Copayment Billing and Adjustments

Generally, when a copayment charge is applicable to a medical service, the billing system determines whether that medical service should result in a copayment amount being charged to a veteran's account based on information recorded by the service provider and the veteran's specific enrollment information, including priority group status. The billing system also tracks all prescription copayment charges billed to a veteran at all medical center sites to ensure that the annual maximum prescription billing cap is not exceeded. For fee basis care, staff at the local VHA facilities who process claims submitted by non-VHA providers for reimbursement for the cost of medical services provided to veterans outside of VHA medical centers also manually establish a veteran copayment charge in the billing system if the medical service in question would have resulted in a copayment charge had the service been provided in a VHA facility.

If a veteran has active third-party health insurance, VHA's policy is to file a claim with the veteran's third-party insurer seeking reimbursement of costs related to medical services covered by the veteran's third-party insurance that were not related to a veteran's service-connected conditions or special treatment authorities. VHA is authorized to pursue reimbursement from third-party insurers regardless of whether the services were provided by VHA or non-VHA providers. Under this policy, VHA is required to apply any related insurance reimbursement received to reduce or eliminate any related pending copayment charges due from

the veteran. As a result, if a veteran has third-party insurance and is subject to a copayment charge, the copayment charge is not billed to the veteran on the monthly statement for up to 90 days to allow time for VHA to receive and apply reimbursement from the veteran's third-party insurer. If the reimbursement received does not fully cover or offset the veteran's copayment obligation, the veteran is responsible for any balance.

Unless reimbursement received from a veteran's third-party health insurer is applied to eliminate or reduce the pending copayment charge, the original copayment charge is released after 90 days, and the charge appears on the veteran's subsequent monthly billing statement. Applicable third-party insurance reimbursement received after the copayment charge is billed to the veteran should still be applied to reduce or eliminate a copayment charge if still unpaid, or used to provide a refund of the billed amount if the veteran has paid the amount. According to VHA procedures, this process, which is known as the third-party insurance offset, is manual and is to be performed on a daily basis after third-party insurance reimbursement is received by local facility staff.

VHA is expected to adjust copayment charges or issue copayment refunds when certain matters related to the billed amount change. When a third-party insurance reimbursement that would fully offset or reduce a billed copayment charge is received, VHA is expected to eliminate or reduce the amount billed to the veteran's account, and if the amount was previously paid by the veteran, VHA is responsible for initiating a refund to the veteran. In addition, when VBA notifies VHA of a new retroactively awarded service-connected condition or an increased disability rating for a veteran, VHA staff are to review the veteran's account to determine whether any previously billed copayment charges for services provided after the effective date of the retroactive VBA award determination should be canceled (if unpaid) or refunded (if paid).

---

# Appendix III: Comments from the Department of Veterans Affairs

---



DEPARTMENT OF VETERANS AFFAIRS  
Washington DC 20420

August 11, 2011

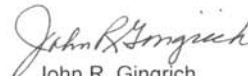
Ms. Susan Ragland  
Director, Financial Management  
and Assurance  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Ragland:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VETERANS HEALTH CARE: Monitoring is Needed to Determine the Accuracy of Veteran Copayment Charges**" (GAO-11-795), and generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses each of GAO's recommendations and provides technical comments on the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

  
John R. Gingrich  
Chief of Staff

Enclosure

Enclosure

**Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
*VETERANS HEALTH CARE: Monitoring is Needed to Determine the Accuracy of  
Veteran Copayment Charges*  
(GAO-11-795)**

**GAO recommendation:** To provide VHA with the information needed to adequately monitor the accuracy of copayment charges VHA-wide and to assess and respond to causes for copayment errors, the Secretary of Veterans Affairs should direct the Veterans Health Administration to take the following two actions:

**Recommendation 1: establish an accuracy performance measure or goal for copayment charges billed to veterans;**

**VA response:** Concur. The Veterans Health Administration (VHA) Chief Business Office (CBO) and Office of Compliance and Business Integrity (CBI) will jointly implement a national performance accuracy measure. Based on GAO's findings, CBO will initially apply a 96 percent accuracy rate performance standard for copayment charges issued to Veterans. This performance standard may be adjusted quarterly to ensure improved accuracy in copayment billing for Veterans. CBO will take appropriate corrective actions to address any instances of non-compliance with the new performance standards. The anticipated implementation date is March 31, 2012.

**Recommendation 2: establish and implement a formal process for periodically assessing– VHA-wide – the accuracy of veteran copayment charges and taking actions as necessary.**

**VA response:** Concur. VHA will implement quarterly system-wide processes to periodically assess the accuracy of Veteran copayment changes and look for any trends.

VHA's CBO will implement an internal monitor for copayment accuracy. For this internal monitoring process, CBO will generate a random sample size from copayment billing activity. The sample will include first party copayment billing data and any associated third party claims. Each Consolidated Patient Account Center (CPAC) Quality Assurance Department will conduct quarterly reviews using the generated sample to monitor copayment charges. The reviews will assess each copayment charge for accuracy related to amount, eligibility category, and third to first party offset.

On a quarterly basis, performance results will be published for each VHA facility and CPAC on the Performance and Operational Web Enabled Reporting (POWER) Web site. CBO will take appropriate corrective actions to address any instances of non-compliance with the new performance standards. Reviews will begin first quarter fiscal year (FY) 2012.

Enclosure

**Department of Veterans Affairs (VA) Comments to  
Government Accountability Office (GAO) Draft Report  
*VETERANS HEALTH CARE: Monitoring is Needed to Determine the Accuracy of  
Veteran Copayment Charges*  
(GAO-11-795)**

VHA's CBI will implement an external verification for copayment accuracy. CBI recently developed an automated national performance metric which identifies potentially inappropriate copayment charges issued to Veterans in Priority Groups 1 through 5. On a quarterly basis, performance results will be published for each VHA facility and CPAC on the CBI Metrics Dashboard. CBI will also provide monthly reports of this data to CBO and facilities for local monitoring. CBO will take appropriate corrective actions to review Veterans' eligibility and copayments, cancel inappropriate copayments, and issue refunds to Veterans as appropriate. Reviews will begin first quarter FY 2012.

---

# Appendix IV: GAO Contact and Staff Acknowledgments

---

## GAO Contact

Susan Ragland, (202) 512-9095 or [raglands@gao.gov](mailto:raglands@gao.gov)

---

## Staff Acknowledgments

In addition to the contact named above, John J. Reilly, Assistant Director; Wilfred Holloway, Assistant Director; Mark Ramage, Assistant Director; Sophie Brown; James Healy; Diane Morris; Quang Nguyen; Gabrielle Perret; Sabrina Rivera; and Matthew Zaun made key contributions to this report.



---

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

---

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site ([www.gao.gov](http://www.gao.gov)). Each weekday afternoon, GAO posts on its Web site newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to [www.gao.gov](http://www.gao.gov) and select "E-mail Updates."

---

## Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's Web site, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

---

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: [www.gao.gov/fraudnet/fraudnet.htm](http://www.gao.gov/fraudnet/fraudnet.htm)

E-mail: [fraudnet@gao.gov](mailto:fraudnet@gao.gov)

Automated answering system: (800) 424-5454 or (202) 512-7470

---

## Congressional Relations

Ralph Dawn, Managing Director, [dawnr@gao.gov](mailto:dawnr@gao.gov), (202) 512-4400  
U.S. Government Accountability Office, 441 G Street NW, Room 7125  
Washington, DC 20548

---

## Public Affairs

Chuck Young, Managing Director, [youngc1@gao.gov](mailto:youngc1@gao.gov), (202) 512-4800  
U.S. Government Accountability Office, 441 G Street NW, Room 7149  
Washington, DC 20548

