NATIONAL ACADEMY OF PUBLIC ADMINISTRATION
900 7th Street, N.W., Suite 600
Washington, DC 20001-3888
TEL (202) 347-3190 FAX (202) 393-0993
INTERNET: www.napawash.org

**Gregg A. Pane, MD**

**Chair**

**VHA Fee Care Program Panel**

**National Academy of Public Administration**

**Before the**

**Committee on Veterans' Affairs**

**Subcommittee on Health**

**U. S. House of Representatives**

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Madam Chairwoman and members of the Committee, I appreciate the opportunity to testify today, on behalf of a Panel I chaired at the National Academy of Public Administration (the Academy) in 2011. Established in 1967 and chartered by Congress, the Academy is an independent, non-profit, and non-partisan organization dedicated to helping leaders meet today's most critical and complex challenges. The Academy has a strong organizational assessment capacity; a thorough grasp of cutting-edge needs and solutions across the federal government; and unmatched independence, credibility, and expertise. Our organization consists of over 700 Fellows—including former cabinet officers, Members of Congress, governors, mayors, and state legislators, as well as distinguished scholars, business executives, and public administrators. The Academy has a proven record of improving the performance and enhancing the accountability of government at all levels.

Over the past decade, the VHA Fee Care Program has grown from an infrequently used adjunct to traditional VA health care services into a critical element of clinical care for veterans. After extensive research and analysis, the Academy's Fee Care Panel recommended that VHA consolidate this program into three to five operating centers while modifying its claim processing structure to become a more standardized system. Standardization of the IT infrastructure along with consolidation will allow fewer employees to work more efficiently and effectively, and a more structured rule-based environment should lead to fewer payment errors and greater program value. The Panel also emphasized the importance of conducting an independent analysis of the costs and benefits for contracting out this function—similar to the approach used by TRICARE and Medicare—to provide important information for Congress and VA.

**BACKGROUND**

The Veterans Health Administration (VHA) provides the majority of medical care services to eligible veterans with Department of Veterans Affairs (VA) assets. In some instances, however, VHA procures the services of health care providers outside of the VA health care system. These services are referred to as "Fee Basis Care" or "Fee Care."

Fee Care is typically utilized when a clinical service cannot be provided by a VA Medical Center (VAMC), when a veteran is unable to access VA health care facilities due to geographic inaccessibility, or in emergencies when delays could lead to life-threatening situations. In recent years, Fee Care has been increasingly used to meet patient wait-time standards.

VA's Fee Care Program expenditures have grown 275 percent since Fiscal Year (FY) 2005. At the time the study was conducted there were approximately 2400 Full Time Employees (FTEs) working in the program. Paid claims rose from $3 billion in FY 2008 to $4.4 billion in FY 2010 (46 percent increase), while the number of unique patients served increased from 820,000 to 952,000 (16 percent) in the same period.

In 2009 and 2010, the VA Office of Inspector General (OIG) reported on significant problems with the accuracy and efficiency of claims paid in the Fee Care Program. The

VA OIG reported that VAMCs made hundreds of millions of dollars in improper payments—including duplicate payments and incorrect amounts, both under- and over-payments—because VHA had not established adequate organizational management structures and processes. The OIG audit report also included a recommendation that VHA evaluate alternative organizational models and payment processing options to identify mechanisms to improve payment processing costs and timeliness. This recommendation provided a primary impetus for this study.

As part of its strategy to improve payments in this Non-VA Care (Fee) Program, VA contracted with the National Academy of Public Administration to conduct an independent assessment of the program, with the intent of providing VHA with options on the most efficient model(s) for its future state.

## THE ACADEMY STUDY

The Academy formed an independent Panel of Fellows to conduct this review with support from a professional study team. The Panel's assessment focused on promoting active participation and direct engagement by all parties involved. The primary methods for collecting information as well as verifying our understanding of VA's internal and external dynamics approach were to:

- Conduct targeted interviews with VA staff and stakeholders.
- Review all existing reports, studies, and audits of the current program.
- Collect and analyze data and metrics regarding the current performance of the existing program from all available sources.
- Interview staff and research the performance of other federal and commercial health care payer programs.
- Prepare an analysis of findings based on the above collection methods for review by the Academy's expert Panel. Draft proposals were sent to VA for consideration and comment prior to finalization.

The study team also met with some of the OIG authors to gain additional insights into the studies. Another recent, highly relevant study was the Indiana University/Purdue University Fee Service Evaluation Project, which examined best practices within 13 VHA claims processing sites and evaluated overall efficiency, operations management, and cost metrics. The Academy study team also interviewed the Indiana University/Purdue University researchers.

In addition to existing reports and studies, another important source of information was site visits. The Academy study team visited the VHA Chief Business Office Field Office and the National Fee Care Program Office in Denver, Colorado, Veterans Integrated Service Networks (VISNs) with consolidated centers, and VISNs that still process claims in individual VAMCs.

The study team also visited Medicare and TRICARE program officials in Falls Church, VA and Denver, CO. Interviews were conducted with officials from some of the major

contractors used by Medicare, Medicaid, and TRICARE to process claims, including TriWest, Health Net, Affiliated Computer Services (ACS), and Humana.

## TRICARE AND MEDICARE MODELS

Both Medicare and TRICARE contract out all of their claims work and spend a majority of their staff time on overseeing the contractors and contracts. Several large commercial vendors specialize in providing large volume processing of these health services claims.

Medicare provides approximately $400 billion in health insurance coverage to people who are aged 65 and over, those who are under 65 with certain disabilities, and people of all ages with end-stage renal disease. The Medicare Program offers an alternative to current VHA organizational structures because all administrative (back-office) functions have been contracted out. Each of five Medicare Regional Offices oversees various activities of the Medicare Administrative Contractors (MAC), which in turn are responsible for providing services to Medicare's enrolled population.

TRICARE's $40 billion a year program has outsourced its administrative office functions, dividing the United Stated into three regions, each awarded to a separate contractor. Contractors are responsible for ensuring that TRICARE's enrolled population receives care, developing and maintaining a network of providers, and maintaining an information system based on guidance established by TRICARE. Taken a step further than Medicare, TRICARE has tried to create contracts that push some "program risks" to the contractors and has created a robust Program Integrity Office with clearly-defined criteria and staff consisting of lawyers, statisticians, physicians and nurses (RNs). This office directs contractors in identifying and limiting fraud and abuse throughout the program.

TRICARE contractors report that about 75 percent of the claims processing is fully automated, that is, not requiring human intervention. The contractors also reported to the study team a cost per claim of $2.25 to $2.50 for electronic claims and $3.50 for paper-based claims. This serves as another basic benchmark to gauge the potential for productivity improvement in the Fee program.

Medicare contractors report that about 95 percent of the claims processing ranges from about $0.40 to $1.60 per claim depending on whether the claim is electronic or paper-based, type of claims, and other factors (compared to $9.40 per claim for VISN 19 and $2.55 for CHAMPVA). Processing of commercial claims cost about the same, ranging from $0.85 per claim for electronic claims to $1.60 for paper-based claims.

## CHAMPVA

VA currently runs a centralized claims processing business line for the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) in Denver, Colorado. CHAMPVA provides coverage for non-VA purchased care provided to the spouse or widow(er) and to the children of a veteran who is rated permanently and totally

disabled due to a service-connected disability or who died of a service-connected disability. In FY 2009 nearly 300 claims processing staff in Denver processed over 6 million CHAMPVA claims annually. The average number of claims processed per staff member is over 20,000. This level of productivity far exceeds the productivity of the most efficient sites for the Fee program, and can be viewed as a target for the Fee program to achieve.

There are certain significant differences between the two programs that add unique challenges to each program. Authorization at the local VA hospital is a significant step in the Fee program that does not occur in CHAMPVA. Likewise, CHAMPVA has some requirements that do not exist in the Fee program. For example, CHAMPVA handles payment or reimbursement of service in foreign countries.

## THE FEE CARE PROGRAM'S CHALLENGES

Several studies and numerous study team interviews point to the following significant challenges and areas for improvement in the Fee Care Program:

- Decentralized mode of operation across VA hospitals resulting in inefficient operations
- High error rates
- Fee Care Program organizational alignment, staffing, grade profiles, education, training, training certification, performance standards and performance expectations vary significantly across VISNs and operating sites
- Interpretation and application of rules vary across Fee operating sites.

The study team's research found:

- Limited VISN-wide executive oversight of purchased care programs
- No clearly defined operational objectives or goals
- No defined strategy for optimally managing program expenditures
- Minimal understanding of the services being procured and prices paid for those services
- No pronounced effort to effectively capitalize on the expertise, resources and economies of scale of the VISN.

### Error Rate Analysis

Three VA OIG audits issued over the last three years report hundreds of millions of dollars in erroneous payments or missed revenue collection opportunities. The Audit of Non-VA Inpatient Fee Care Program report (August 18, 2010), for example, concluded in its report highlights:

> "VA Medical Centers (VAMCs) improperly paid 28 percent of inpatient Fee claims during the 6-month period of January 1, 2009 through June 30, 2009. The improper payments occurred because VHA's policies for determining eligibility for inpatient Fee care did not provide adequate guidance on how to determine eligibility for inpatient Fee care or were not understood by Fee staff. Other payment errors occurred

> because Fee staff did not have accurate and timely information to determine correct payments, and the VAMC did not have sufficient controls to detect clerical errors. We estimate that VHA made net overpayments of $120 million on inpatient care for veterans in FY 2009 or $600 million in improper payments over the next 5 years."

The VHA's Chief Business Office (CBO)'s own analysis of error rates in claims processing for recent activity is about 12 percent. This measure of error rate is net of under and over charges on the billing. It does not include procedural errors or errors that do not result in inaccurate billing. An error rate of 12 percent applied against total Fee expenditures in FY 2011 indicates erroneous payments of $500,000,000. The FY 2011 error rate of 12 percent is an improvement over the rate reported the previous year (13.8 percent).

For a comparative benchmark, CBO reported to the study team that the national error rate for CHAMPVA for this year is 1.03 percent. This is based on using the same measurement processes (payment error compared to total payments) that was used to calculate the Fee Basis payment error rate of 12 percent.

The TRICARE program may serve as an example of high performance with respect to management of improper payments as well. In interviews TRICARE program integrity officials reported error rates that are under .05 percent.

TRICARE's Program Integrity office executes policies and procedures regarding prevention, detection, investigation and control of fraud, waste and program abuse. It provides oversight of contractor program integrity activities. It liaises with Department of Justice, law enforcement agencies, state and federal agencies, and private plans. TRICARE program integrity tools include: mandated use of fraud detection software; automated computer edit software program; post-pay duplicate software; quarterly and annual audits; prepayment review; beneficiary/provider education; and anti-fraud data mining (e.g., spike detection, outliers). TRICARE maintains and tracks electronic records of all adjudicated purchased care claims in its TRICARE Encounter Data (TED).

**PANEL FINDINGS**

The Fee Care Program is currently operating at an inefficient level due to the number of claim payment errors and the relatively low productivity of its staff compared to other similar programs. In fact, the return on investment (ROI) analysis run by the Panel indicates that a total consolidation of the Fee Care Program (which is a combination of virtual and VISN consolidation) would save the organization almost $4 billion in the next 10 years, net of the investment costs. The net total savings was calculated by adding the amount of net savings affected by reducing the number of FTEs through consolidation, integrating a more automated claims processing system, and reducing the errors in payments.

A consolidation effort would maximize efficiency and reduce staffing levels. After reviewing the costs and running a ROI analysis, the Panel has concluded that total

consolidation shows more efficiency, lower error rates, lower resource needs, and over all higher return on investment. The standardization of the IT infrastructure along with physical consolidation will allow a smaller number of employees to work more efficiently and with a more structured rule-based environment resulting in a decrease in errors made while processing claims.

The Department of Veterans Affairs' Fee Care Program needs to change. Historically, this program constituted a small fraction of health care resources. The Panel estimated that it would constitute approximately 10 percent of the VA's total health care budget in FY 2012. During this period of unprecedented growth, the organizational, administrative, and technological systems used to operate and manage the program simply have not kept pace. VA is different from most federal health care systems in that it is both a provider of health care and a payer of health care claims.

The Panel reached the following conclusions:

1. Given the significant organizational and productivity challenges within the Fee Care Program, VHA has limited understanding of the services it is procuring through this program or their costs.

2. The Fee Care Program is significantly more inefficient and has higher error rates than benchmarked organizations. Productivity across operating sites varies considerably. CBO estimates the error rates (that is, erroneous payments) at 12 percent per year, or approximately $500 million in FY 2011. By contrast, TRICARE has a reported error rate of 0.42 percent. Productivity varies so greatly across operating sites that the productivity of the most efficient processing site is nearly 10 times greater than the most inefficient site.

3. The Fee Care Program has grown haphazardly over the years and the technology and administration of Fee care claims have been neglected. As VA's Fee Care Program has grown, the Department has been playing catch-up in its attempts to modernize and improve its decentralized and inefficient claims processing system. Despite a number of initiatives being undertaken to improve the current situation, the organization responsible for improving the system, CBO, has limited control and authority.

4. VA has an opportunity to create a markedly improved Fee claims system but faces major challenges. In addition to the significant changes recommended for VHA field operations outlined below and the needed technology enhancements, the Panel also believes that CBO needs to change the organizational alignment within the Fee office to achieve more focus, effective leadership, and improved lines of authority to bring about the necessary changes.

5. CBO has struggled to meet its mandate to provide a single accountable authority to develop administrative processes, policy, regulations, and directives regarding the delivery of VA health benefit program.

6. The support environment within VA and VHA—particularly IT, HR and Contracting—plays key roles in improving the functioning of the Fee Care Program. The Panel believes that strong leadership support from senior VA and VHA officials will be required to provide the Fee Care Program with the institutional support required to bring about the recommended changes.

7. Although the Fee Care Program can significantly improve just by changing its organizational and administrative processes, the most significant performance breakthroughs can take place only through technology. Two excellent examples of how technology can do this are the Medicare and TRICARE programs, which respectively handle 90 percent plus and 75 percent of their claims without human intervention. VA in contrast, cannot process any claims without human intervention.

8. CBO also needs to develop stronger program management capabilities. Although CBO does not exercise direct line authority over field Fee operations, they still can develop mechanisms that can help to drive desired outcomes by using the traditional tools available to program managers:
    - Metrics – CBO needs a balanced set of metrics to oversee Fee operations in the field. This would include measures of speed, accuracy, costs and customer satisfaction.
    - Data – reliable performance data is essential for Fee Care Program oversight. This study found numerous examples of questionable and clearly erroneous data used in Fee Care Program reports. It was also clear that this information was not being adequately reviewed by Program officials.
    - Program integrity – CBO should create and manage a program integrity component in each of the consolidated operating centers as well as at its headquarters for determining whether work is being done in the prescribed manner.
    - Use existing authority – both CBO and all VISN directors report to the Deputy Under Secretary for Health/Operations and Management. In matters of insuring field business office structural and business process consistency, this office should exercise more direct control.

Over the past decade, the Fee Care Program has grown from a small, relatively infrequently used adjunct to traditional VA health care services, into a critical element of clinical care for veterans. While the Fee Care Program has grown exponentially in terms of volume and budget outlays, there has been insufficient strategic oversight of the program and its administrative and support systems have languished.

## PANEL RECOMMENDATIONS

After analyzing the costs and ROI, the Panel concluded that consolidating the Fee Care Program into three to five operating centers while modifying its claim processing

structure to become a more standardized system is the appropriate course of action in order to increase effectiveness and efficiency. Standardization of the IT infrastructure along with consolidation will allow fewer employees to work more efficiently and effectively. A more structured rule-based environment would lead to fewer payment errors and greater program value.

More specifically, the Panel recommended that VHA take the following steps to strengthen the Fee Care Program:

**Organizational Consolidation and Management Changes**

1. Consolidate its Fee Care Program from the current 100+ operating sites to the smallest number possible that will provide necessary redundancy and surge capabilities. This should result in no more than three to five strategically located regional sites.

2. High level VA management should provide clear policy direction about performance goals and expectations for VA purchased care, including the allocation of resources between VA-provided and purchased care to best meet strategic goals.

3. VHA should build greater program management competence and capacity for overseeing the Fee Care Program and supporting the consolidated claims processing sites. VHA should look both within and external to VA for expertise in this effort.
    - Create and manage a program integrity component in each of the claims processing sites, in addition to the planned headquarters component.
    - Establish a performance management system having performance metrics for productivity, accuracy, timeliness and customer satisfaction, among other things.
    - VHA should establish short and long-term performance goals.
    - Build greater program management competence for overseeing the Fee program.

**Technology and Virtual Consolidation**

4. VHA should procure and implement an enterprise-wide technology solution to facilitate virtual consolidation.

**Other Considerations**

5. Conduct a cost-benefit analysis of contracting out the processing of claims as with other payer models (such as TRICARE, Medicare, Medicaid, and Blue Cross Blue Shield) and their applicability for VA. This was outside the scope of the Academy Panel's mandate in this study.

By implementing these recommendations, the Panel believes that VA will improve service to Fee Care providers, which will help ensure maximal participation in the Fee Care Program and, consequently, more available health care options for veterans. The savings gained from more efficient administration and more accurate payments can be redirected back into improving other health care services for veterans.

Madam Chairwoman, that concludes my prepared statement, and I would be pleased to answer any questions you or the Committee members may have.