



March 2014

VA HEALTH CARE

Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit

GAO Highlights

Highlights of [GAO-14-175](#), a report to congressional requesters

Why GAO Did This Study

VA spent an estimated \$418 million on Millennium Act emergency care claims in fiscal year 2012 and projects spending will increase to \$580 million by fiscal year 2015. GAO was asked to review VA's administration of the emergency care benefit under the act. This report examines the extent to which (1) selected VA facilities complied with applicable requirements, in particular when denying claims; (2) VA's oversight activities ensure that Millennium Act claims are not inappropriately denied; and (3) veterans understand the Act's emergency care benefit and how VA communicates with non-VA providers about Millennium Act claims.

To do this work, GAO reviewed 4 VA facilities out of 142 based on variations in Millennium Act spending levels and geographic location. GAO also reviewed VA documents—including 128 denied Millennium Act claims from these four facilities—and interviewed officials from VA, non-VA providers, and veterans service organizations. These results cannot be generalized across VA but provide insights.

What GAO Recommends

GAO recommends that VA take a number of actions, including steps to ensure facilities comply with applicable requirements, notify veterans of denials, improve oversight of claims processing, and collect better data on denials and veterans' understanding of eligibility for Millennium Act coverage. VA agreed with the recommendations and described its plans to implement them. However, as described in the report, GAO believes that some of VA's proposed actions do not fully address the issues identified.

View [GAO-14-175](#). For more information, contact Randall Williamson at (202) 512-7114 or williamsonr@gao.gov.

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What GAO Found

The Veterans Millennium Health Care and Benefits Act (Millennium Act) authorizes the Department of Veterans Affairs (VA) to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers. However, GAO identified a number of instances where VA staff who processed claims did not comply with applicable requirements of the Millennium Act, its implementing regulations, or VA policies when they denied the claims. Specifically, at the four VA facilities included in this review, GAO found 66 instances of noncompliance among the 128 denied claims reviewed, which led some claims to be inappropriately denied. VA facilities subsequently reconsidered and paid 25 of these claims. GAO also found that VA facilities may not be notifying veterans as required that their Millennium Act claims have been denied. Eighty-three claims out of 128 that GAO reviewed lacked documentation that the veteran was notified of the denial or of his or her appeal rights. These findings suggest that veterans whose claims have been inappropriately denied may have been held financially liable for emergency care that VA should have covered, and they may not be aware of their rights to appeal these denials.

GAO also found that, as a result of weaknesses in VA's oversight of Millennium Act claims, VA facilities are at risk for inappropriately denying such claims. For example, agency oversight activities do not focus on compliance with all applicable requirements but rather on the timeliness of claims processing. In addition, VA has limited assurance that deficiencies relating to Millennium Act claims processing identified during reviews are corrected because it only conducts limited follow-up with VA facilities. Moreover, VA does not collect adequate data for monitoring the appropriateness of Millennium Act claim denials. This lack of data hinders VA's ability to track patterns as to why Millennium Act claims are denied and identify areas where communications with veterans and non-VA providers about Millennium Act emergency care benefits could be improved.

VA has used various methods to educate veterans about their Millennium Act eligibility; however, VA officials, non-VA providers, and representatives of veterans service organizations told GAO that veterans still lack knowledge about their eligibility. For example, VA officials reported that because some veterans were uninformed about their eligibility, these veterans may have delayed or avoided seeking treatment at local non-VA providers, choosing instead to go to a less accessible VA facility. Because VA does not require facilities to conduct evaluations of veterans' understanding of Millennium Act eligibility, it lacks information needed to address potential gaps in veterans' knowledge about these benefits. Also, the non-VA providers GAO interviewed cited communication challenges with VA regarding Millennium Act claims, such as not having a specific point of contact at VA for directing specific questions and raising concerns, and a lack of VA responsiveness when issues are raised. Despite VA's efforts to improve communications with non-VA providers after a 2011 customer service survey revealed significant issues, these challenges persisted at the facilities GAO visited.

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Abbreviations

FBCS	Fee Basis Claims System
Millennium Act	Veterans Millennium Health Care and Benefits Act
VA	Department of Veterans Affairs
VSSC	Veterans Integrated Service Network Support Service Center

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March 6, 2014

Congressional Requesters

The Veterans Millennium Health Care and Benefits Act (Millennium Act), enacted in 1999, provides a safety net for veterans who receive emergency care related to nonservice-connected conditions from non-Department of Veterans Affairs (VA) providers.¹ Prior to the Millennium Act, VA only had the authority to pay for emergency care related to a veteran's service-connected disability, and veterans with medical emergencies were reportedly trying to bypass local community hospitals to obtain care at VA facilities in order to avoid receiving medical bills.²

According to VA estimates, VA spent more than \$418 million on Millennium Act emergency care claims in fiscal year 2012.³ VA projects that this spending will increase to \$580 million by fiscal year 2015. Millennium Act coverage for veterans' nonservice-connected emergency care services has a number of conditions, including that the veteran receiving the care be enrolled in VA's health care system and have received treatment from a provider at a VA facility in the last 24 months; be financially liable for the care and have no coverage under another health plan, such as Medicare or a private health insurance plan; and that the claim be filed in a timely manner.⁴ In fiscal year 2012, more than 8 million veterans were enrolled in VA health care, and VA Central Office estimated that about 23 percent of these veterans had no other health

¹Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (codified, as amended, at 38 U.S.C. § 1725). Non-VA providers include hospitals and other health care providers, such as individual physicians and physicians' groups.

²Emergency care related to a service-connected disability is payable under 38 U.S.C. § 1728(a)(1)-(3).

³VA spent a total of \$54 billion on veterans' health care services in fiscal year 2012.

⁴The claim must be filed within 90 days of the latest of the following: date of discharge; date of death, provided death occurred during transport to or stay in an emergency treatment facility; or date that the veteran exhausted actions, without success, to obtain payment or reimbursement from a third party. 38 C.F.R. § 17.1004(d).

insurance, making them potentially eligible for Millennium Act emergency care coverage.⁵

Since the enactment of the Millennium Act, concerns have been expressed about how VA medical facilities make decisions about coverage of emergency care for veterans from non-VA providers, including the denial of claims, and the extent to which VA educates veterans and non-VA providers about Millennium Act emergency care eligibility. You also asked us to review VA's implementation of the Millennium Act and the effectiveness of VA policies related to informing veterans about how emergency care claims are reimbursed. This report examines the extent to which (1) selected VA facilities comply with applicable requirements when denying Millennium Act emergency care claims; (2) VA, through its oversight activities, ensures that Millennium Act emergency care claims are not inappropriately denied; and (3) veterans understand the Millennium Act emergency care benefit and how VA communicates with non-VA providers about Millennium Act emergency care claims.

To examine VA facilities' compliance with applicable requirements when denying Millennium Act emergency care claims, we reviewed the Millennium Act and its implementing regulations, as well as VA policies and guidance related to processing Millennium Act emergency care claims.⁶ We also conducted site visits to four VA facilities selected on the basis of their Millennium Act spending levels for fiscal year 2012 and geographic variation, including whether they predominantly serve veterans from rural areas.⁷ Rurality is an important consideration for this study because veterans may have to travel long distances to reach a VA facility or a non-VA provider during an episode of emergency care.⁸ The

⁵The estimate of the percentage of enrolled veterans with no other health insurance is weighted and based on responses from a representative sample of 42,000 veterans who were enrolled in VA health care as of September 30, 2011.

⁶The Millennium Act and its implementing regulations appear at 38 U.S.C. § 1725 and 38 C.F.R. §§ 17.1000 – 17.1008, respectively.

⁷For the purposes of this report, we considered VA facilities to be health care systems, which are typically made up of one or more VA medical centers, or stand-alone VA medical centers.

⁸We included the Black Hills Health Care System and the White River Junction VA medical center in our sample because they serve veterans who live in rural or highly rural areas, according to VA's Office of Rural Health.

four VA facilities represented a range of Millennium Act spending for fiscal year 2012. (See table 1.) We also reviewed documentation associated with 128 Millennium Act emergency care claims that were denied in fiscal year 2012, approximately 30 denied claims from each of the four VA facilities we visited. These denied claims were selected on the basis of variation in the total billed charges, diagnoses, veterans' ages, and gender, and reflected the distribution of Millennium Act denial reasons recorded by the facility on all of the Millennium Act emergency care claims it denied in fiscal year 2012. In addition, we conducted interviews with officials from VA Central Office and the four VA facilities we visited.⁹ To assess the reliability of the Millennium Act spending data we used to select VA facilities and the claims data we used to select denied Millennium Act emergency care claims, we conducted interviews with knowledgeable agency officials, manually reviewed the content of the data, and electronically tested the data for missing values, outliers, and obvious errors. We found these data to be sufficiently reliable for selecting our samples of VA facilities and denied Millennium Act claims. Since these samples were not intended to be representative, our findings cannot be generalized to all VA facilities or all denied Millennium Act emergency care claims.

⁹We interviewed VA Central Office officials from the Chief Business Office for Purchased Care, the office responsible for overseeing the National Non-VA Medical Care Program across the VA health care system. The Non-VA Medical Care Program was previously known within VA as the fee basis care program. For purposes of this report, we will use the term fee basis care to refer to non-VA medical care. Fee basis is the practice of paying for veterans' health care services outside of VA when VA medical facilities are not feasibly available. This may include situations in which there is a lack of available VA specialists, there are long wait times for appointments, or there is an extraordinary distance between the VA facility and the veteran's home. Millennium Act claims are a type of fee basis claim.

Table 1: Site Visit Locations

Total Millennium Act fiscal year 2012 spending (millions)	VA facility (location)
\$ 12.8	North Texas VA Health Care System ^a (Texas)
\$ 3.0	Washington DC VA Medical Center (Washington, DC)
\$ 1.4	Black Hills VA Health Care System ^b (South Dakota)
\$ 1.0	White River Junction VA Medical Center (Vermont)

Source: VA data.

^aThe North Texas VA Health Care System is made up of the Dallas and Bonham VA Medical Centers.

^bThe Black Hills VA Health Care System is made up of the Hot Springs and Fort Meade VA Medical Centers.

To examine the extent to which VA ensures that Millennium Act emergency care claims are not inappropriately denied, we reviewed VA documents and interviewed officials from VA Central Office and the four VA facilities we visited. In addition, we assessed VA Central Office's and VA facilities' efforts to ensure that Millennium Act emergency care claims are not inappropriately denied in the context of federal standards for internal controls for (1) monitoring and (2) information and communications.¹⁰ The internal control for monitoring relates to an agency's ability to provide reasonable assurance that deficiencies are detected and promptly resolved. The internal control for information and communications relates to an agency's access to information needed to carry out its oversight responsibilities.

To determine the extent to which veterans understand the Millennium Act emergency care benefit, we reviewed relevant VA documents and websites. We also interviewed (1) officials from VA Central Office; (2) VA facility officials responsible for (a) reviewing and paying Millennium Act emergency care claims, (b) assisting veterans with problems encountered while seeking care at the facility, and (c) enrolling and informing veterans about their health care benefits; and (3) representatives from three veterans service organizations.¹¹ In addition, we assessed VA Central

¹⁰See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

¹¹We interviewed VA Central Office officials from the Health Eligibility Center and the Chief Business Office for Purchased Care, and officials from the American Legion, Disabled American Veterans, and Veterans of Foreign Wars of the United States.

Office's and VA facilities' efforts to evaluate gaps in veterans' knowledge of the Millennium Act emergency care benefit in the context of federal standards for internal control for risk assessment. The internal control for risk assessment relates to the identification and analysis of relevant risks associated with achieving the agency's stated objectives.¹² For the four VA facilities we visited, we also reviewed veterans' complaints related to VA eligibility issues that were entered in the Patient Advocate Tracking System in fiscal year 2012 and any Millennium Act-related appeals filed by veterans with the Board of Veterans' Appeals from fiscal year 2010 through the time of our site visits in 2013.¹³ To describe how VA communicates with non-VA providers about Millennium Act emergency care claims, in addition to VA Central Office and VA facility officials mentioned earlier, we also interviewed representatives of four non-VA providers that submitted Millennium Act claims for payment to the VA facilities we visited.¹⁴ In addition, we conducted a literature review of academic articles relating to veterans' awareness of emergency care availability at non-VA providers and reviewed relevant VA resources available to non-VA providers, such as an electronic newsletter and website.

¹²See [GAO/AIMD-00-21.3.1](#).

¹³Patient advocates are VA employees who are specifically designated at each facility to receive complaints from veterans and their representatives and work directly with management and employees to facilitate resolutions. Patient advocates are typically responsible for entering and tracking complaints and concerns in the Patient Advocate Tracking System. We analyzed data associated with the four issue codes relating to VA eligibility issues. Based in Washington, D.C., the Board of Veterans' Appeals is composed of judges experienced in veterans' law. The Board reviews benefit determinations made by local VA offices and issues decisions on appeals. Only two of the four facilities we visited had defended any appeals related to Millennium Act claims to the Board of Veterans' Appeals from fiscal year 2010 through the time of our site visits in March and April 2013. We reviewed four appeals in total.

¹⁴We interviewed officials from a total of four non-VA providers: three hospitals with the highest volume of inpatient and outpatient Millennium Act emergency care claims denied in fiscal year 2012 by their associated VA facilities and one physicians' group with the highest volume of inpatient and outpatient Millennium Act emergency care claims denied in fiscal year 2012 by its associated VA facility. We interviewed officials from non-VA hospitals that had submitted claims to the North Texas VA Health Care System, the Black Hills VA Health Care System, and the White River Junction VA Medical Center. The physicians' group had submitted claims to the North Texas VA Health Care System. We contacted officials from two non-VA providers that had submitted claims to the Washington DC VA Medical Center, but they did not respond to our interview requests.

We conducted this performance audit from April 2013 to March 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

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- Types of Fee Basis Claims** Non-VA care services provided at non-VA facilities, referred to as fee basis services, are either
- emergent in nature and therefore would not have gone through the traditional VA preauthorization process, or
 - preauthorized—that is, authorized in advance by VA; for example, by a referral for a consultation with a specialist from the veteran’s primary care provider.¹⁵

See table 2 for a description of the types of fee basis claims processed by VA.

¹⁵For more detail regarding the preauthorization process see GAO, *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013). Emergency care may become authorized if VA is notified within 72 hours of the episode of care that the veteran has sought care at a non-VA facility. Emergency care at a non-VA facility may also be authorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA facility.

Table 2: Types of Fee Basis Claims Processed by VA and Relevant Payment Authority

Type of claim	Description and relevant payment authority
Emergency care	Services without VA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash)
Veterans Millennium Health Care and Benefits Act (emergency care for conditions not related to service-connected disabilities)	Services meeting criteria under 38 U.S.C. § 1725
Emergency care for conditions related to service-connected disabilities	Services meeting criteria under 38 U.S.C. § 1728
Preauthorized ^a	Services with prior VA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)

Source: GAO analysis of VA policies.

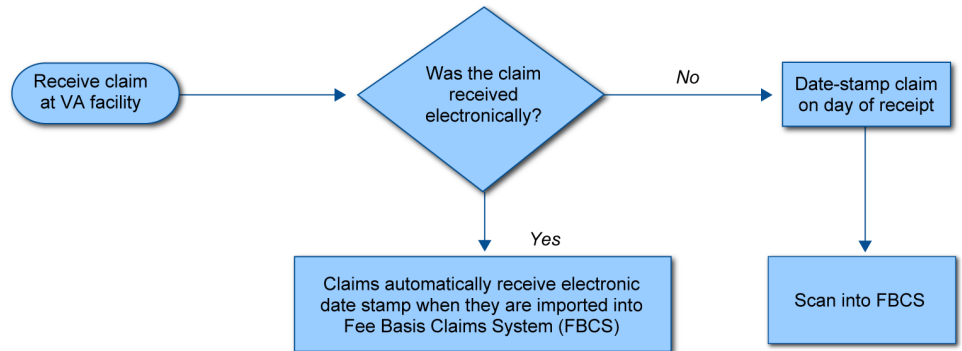
^aIn certain circumstances, emergency care provided by fee basis providers can be deemed preauthorized if the providers provide notification of a veteran's admission within 72 hours. Emergency care by fee basis providers may also be preauthorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA facility.

Fee Basis Claims Process

To process all fee basis claims, including Millennium Act claims, VA facilities use software called the Fee Basis Claims System (FBCS). FBCS is primarily a system that helps VA facilities administer payments to non-VA providers, as opposed to a system that automatically applies relevant criteria and determines whether claims are eligible for payment. As a result, VA relies on fee basis staff, such as administrative clerks and clinicians (typically nurses), to make decisions about which fee basis claims are eligible for payment and which payment authority applies to the claim. (See app. I for a flow chart describing how fee basis claims are processed, specifically Millennium Act claims.)

Non-VA providers submit claims, including Millennium Act claims, to VA facilities for processing and payment either in hard copy form or electronically. According to VA policy, hard copy claims must be date-stamped upon receipt and scanned into FBCS. (See fig. 1.)

Figure 1: VA's Process for Receiving Fee Basis Claims



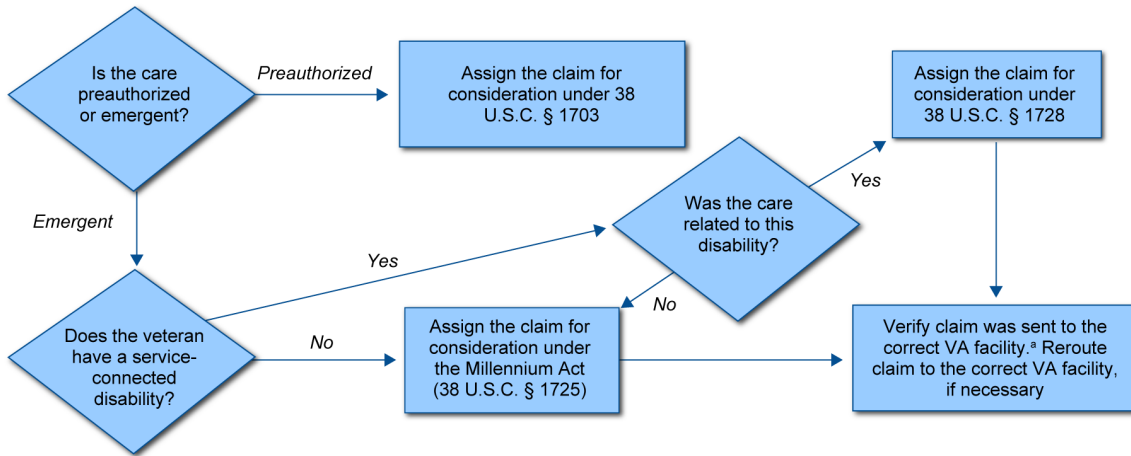
Source: GAO.

Once a fee basis claim is received, fee basis staff are responsible for assigning the relevant payment authority and ensuring it has been routed to the correct VA facility. According to VA policy, fee basis staff should check FBCS to determine if the care was preauthorized or emergent to determine payment authority and proceed as follows (see fig. 2):

- If a claim was preauthorized, it should be assigned within FBCS as preauthorized.
- If the care was not preauthorized, the claim should be assumed to be emergent care. Fee basis staff should then check FBCS to determine if the veteran has a service-connected disability. If the emergent care was related to the veteran's service-connected disability, the claim should be considered under 38 U.S.C. § 1728. If the emergent care was not related to a service-connected disability, the claim should be considered under the Millennium Act. Clinicians should make the final determination of whether the emergency care is related to the veteran's service-connected disability.¹⁶

¹⁶If a claim is initially assigned for consideration under 38 U.S.C. § 1728 (emergency care related to a service-connected disability), but a clinician later determines that the claim is not for care related to the veteran's service-connected disability, fee basis staff should reassign the claim for consideration under the Millennium Act.

Figure 2: VA's Process for Determining Payment Authority and Verifying That Emergency Care Claims Were Routed to Correct VA Facility



Source: GAO.

^aThe correct VA facility for considering a Veterans Millennium Health Care and Benefits Act (Millennium Act) claim is the facility of jurisdiction—the VA facility geographically located closest to the non-VA provider where the emergency care services were rendered. In cases where the non-VA provider is geographically located closest to a VA community-based outpatient clinic, the Millennium Act claim should be routed to the VA facility responsible for processing that clinic's fee basis claims. The correct VA facility for considering an emergency care claim that is related to the veteran's service-connected disability is the clinic of jurisdiction, which is the VA facility responsible for serving the county in which the non-VA provider that rendered the services is located.

After assigning an emergency care claim to the appropriate payment authority, fee basis staff should ensure that the claim has been routed to the correct VA facility, according to VA policy. The correct VA facility for considering a Millennium Act claim—that is, a claim for emergency care that is not related to a service-connected disability—is the VA facility geographically located closest to the non-VA provider where the emergency care services were rendered (called the facility of jurisdiction).¹⁷ The correct VA facility for considering an emergency care claim that is related to the veteran's service-connected disability is the VA facility responsible for serving the county in which the non-VA provider that rendered the services is located (called the clinic of jurisdiction). If the claim was routed to the incorrect VA facility, fee basis staff must forward the claim to the correct VA facility.

¹⁷In cases where the non-VA provider is geographically located closest to a VA community-based outpatient clinic, the Millennium Act claim should be routed to the VA facility responsible for processing that outpatient clinic's fee basis claims.

Millennium Act Emergency Care Criteria

All of the following administrative and clinical criteria must be met in order for the services to be paid for by VA.

- Administrative criteria for payment of Millennium Act emergency care claims
 - Claim is not payable under 38 U.S.C. § 1728 (emergency care for conditions related to service-connected disabilities).
 - Claim is filed within 90 days of the latest of the following: the date of discharge; date of death, provided death occurred during transport to or stay in an emergency treatment facility; or date that the veteran exhausted, without success, action to obtain payment or reimbursement from a third party.
 - Veteran is enrolled in the VA Health Care System and has received treatment from a VA clinician within 24 months of the emergency care episode.
 - Veteran is financially liable to the non-VA provider of emergency care.
 - Veteran has no entitlement to care under a health plan contract (such as Medicare or a private health insurance plan).¹⁸
 - Veteran has no other contractual or legal recourse against a third party that would in whole extinguish his liability to the non-VA provider.¹⁹
- Clinical criteria for payment of Millennium Act emergency care claims
 - Services were rendered in a hospital emergency department or a similar facility providing emergency care to the public.

¹⁸The 2010 amendments to the Millennium Act changed the definition of a health plan contract to exclude state laws requiring motor vehicle drivers to have auto insurance as a source of coverage. Act of Feb. 1, 2010, Pub. L. No. 111-137, §1(a)(2), 123 Stat. 3495.

¹⁹The 2010 amendments to the Millennium Act also authorized VA to pay for treatment when a veteran has recourse against a third party for a portion, but not all, of the veteran's liability. In such cases, VA becomes the secondary payer, such as when auto insurance only partly covers the veteran's liability to the non-VA provider.

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- Services were rendered in a medical emergency as determined using the prudent layperson standard.²⁰
 - VA or other federal facility was not feasibly available to provide the needed care, and an attempt to use either would not have been considered reasonable by a prudent layperson.
 - Services needed before veteran was stable enough to be transferred to a VA or other federal facility and before the VA or other federal facility agreed to accept the transfer.

Applying Millennium Act Administrative and Clinical Criteria

According to VA policy, fee basis staff must first apply the Millennium Act administrative criteria to determine if the claim warrants further clinical consideration. Fee basis staff responsible for reviewing Millennium Act criteria must gather information about a veteran and the episode of care from a variety of sources, such as FBCS, VA's electronic medical record, and the non-VA provider, in order to make decisions about whether claims are eligible for payment.²¹ If a claim meets all administrative criteria, fee basis staff should route the claim to a clinician for review of the Millennium Act clinical criteria.

²⁰A medical emergency exists when the condition is of such a nature that a prudent layperson would reasonably expect that delay in seeking immediate medical attention would be hazardous to life or health. The standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. See 38 C.F.R. § 17.1002(b). The prudent layperson standard emphasizes the patient's presenting symptoms, rather than the final diagnosis, when determining whether to pay emergency medical claims.

²¹If additional information is needed to process the claim, such as medical records from the non-VA provider relating to the episode of care, the fee basis staff who review Millennium Act administrative criteria are typically responsible for requesting this information from non-VA providers. Any additional information requested by VA must be submitted within 30 days of receipt of the request or VA will treat the claim as abandoned, that is, take no further action on the claim, unless, within the 30 day period, the claimant requests additional time in writing.

Notifying Veterans and Non-VA Providers of Millennium Act Claim Denials

VA must provide written notice to the veteran and the claimant (usually, the non-VA provider) regarding the reason for the denial and inform them of their rights to request a reconsideration or to formally appeal the denial. If a veteran or non-VA provider has questions about a denied claim, claims should be reconsidered by a fee basis supervisor at the same facility. If the denial decision is upheld, the veteran or non-VA provider has the right to file an appeal through the Board of Veterans' Appeals.

Selected VA Facilities Did Not Consistently Comply with Applicable Requirements for Processing Claims and Notifying Veterans When Denying Millennium Act Claims

Our review of 128 denied Millennium Act claims from the four VA facilities we visited identified patterns of noncompliance with applicable requirements. As a result, some claims were inappropriately denied. In addition, we found that VA facilities may be failing to notify veterans that their Millennium Act emergency care claims have been denied. These findings suggest that veterans whose claims have been inappropriately denied may become financially liable for emergency care that VA should have covered, and they may not be aware of their rights to appeal these denials.

Selected VA Facilities Erroneously Denied Millennium Act Claims Because of Noncompliance with Certain Applicable Requirements

Among the 128 denied Millennium Act claims we reviewed, we found 66 instances of noncompliance with applicable requirements that could be categorized into one of the following five areas: (1) not date-stamping and promptly scanning claims; (2) assigning claims to the incorrect payment authority; (3) not routing claims to the correct VA facilities; (4) incorrectly determining veterans' enrollment and use of VA services; and (5) denying motor vehicle crash-related claims with insufficient documentation, which led some claims to be inappropriately denied. Some of the claims we reviewed exhibited more than one area of noncompliance. As a result of our review, the four VA facilities reconsidered and paid 25 of the

Millennium Act claims we reviewed that had been inappropriately denied.²²

Claims Were Not Date-Stamped and Not Scanned Promptly

The 128 Millennium Act claims we reviewed were rarely date-stamped by fee basis staff. Of the small percentage of claims we reviewed that had been date-stamped, almost all were submitted electronically and automatically received electronic date stamps when they were imported into FBCS. (See table 3.) VA policy requires facilities to date-stamp incoming claims so that fee basis staff can determine whether claims were submitted in a timely manner. Millennium Act claims must be received within 90 days of the latest of the following: the date of discharge; the date of the patient’s death, provided death occurred during transport to or stay in an emergency treatment facility; or the date that the veteran exhausted, without success, actions to obtain payment or reimbursement from a third party. VA can deny claims submitted after 90 days.

Table 3: Hard Copy Millennium Act Claims Reviewed that Were Not Date-Stamped, at Four Selected VA Facilities

VA facility	Total number of denied Millennium Act claims reviewed	Total number of denied Millennium Act claims submitted by hard copy	Number of hard copy Millennium Act claims not date-stamped	Percentage of hard copy Millennium Act claims not date-stamped
Black Hills VA Health Care System	34	34	34	100%
North Texas VA Health Care System	32	22	22	100%
Washington DC VA Medical Center	30	27	24	89%
White River Junction VA Medical Center	32	27	27	100%

Source: GAO analysis of Millennium Act claims.

²²Among the 128 claims we reviewed, there were instances of noncompliance with applicable requirements and, in some cases, insufficient documentation to substantiate the denial reasons indicated in FBCS. Thirty-four of the claims we reviewed had insufficient documentation to substantiate the denial reasons. The four VA facilities reconsidered a total of 42 claims that exhibited noncompliance or lacked documentation to substantiate reasons for denial, or otherwise raised doubts about whether they should have been denied. There are several reasons that VA facilities did not pay all 42 of these reconsidered Millennium Act claims. For example, in some cases, it was determined that the claims should have been denied for reasons other than those indicated in FBCS. In other cases, it was determined that duplicate versions of the claims had already been paid prior to our review.

We also found a significant percentage of hard copy Millennium Act claims with FBCS scan dates 30 or more days after the date the non-VA provider created the claims, raising questions about whether the claims were scanned promptly by VA staff when they were received.²³ (See table 4.) VA policy requires facilities to scan incoming hard copy claims into FBCS upon receipt. Staff at three of the four VA facilities acknowledged that they had sometimes experienced delays and backlogs in scanning incoming claims. For example, staff at one facility explained that they had inherited a backlog of unscanned fee basis claims when they began working in the fee office about 4 years ago, because their predecessors had reportedly ignored a large volume of claims and never scanned or processed them. Staff at another facility said that they experienced scanning delays because their scanning equipment was frequently broken.

Table 4: Hard Copy Millennium Act Claims Reviewed with Scan Dates 30 Days or More after Creation Dates, at Four Selected VA Facilities

VA facility	Number of hard copy Millennium Act claims with scan dates 30 or more days after claim creation date	Total number of hard copy Millennium Act claims reviewed	Percentage of denied Millennium Act claims with scan dates 30 days or more after claim creation date
Black Hills VA Health Care System	6	34	18%
North Texas VA Health Care System	7	22	32%
Washington DC VA Medical Center	11	27	41%
White River Junction VA Medical Center	10	27	37%

Source: GAO analysis of Millennium Act claims.

Note: Because these claims had scan dates that were 30 or more days after the dates the non-VA providers created the claims, it does not appear that the VA facilities scanned them on the date they were received.

None of the four VA facilities we visited had developed local policies or standard operating procedures to clearly communicate which staff at the facility are responsible for date-stamping and scanning incoming fee basis claims. Because the four VA facilities we visited had no local policies or standard operating procedures to delineate date-stamping and scanning responsibilities, and because fee basis staff at the four facilities

²³We compared the creation date on the claim form with the scan date on the FBCS claim history for each claim. In cases where more than 30 days had elapsed between the creation date and the scan date, we concluded that there had been a delay in scanning the claim.

Claims Were Not Correctly
Assigned for Millennium Act
Consideration

were not following VA's policies on date-stamping and scanning claims into FBCS, they may have inappropriately denied Millennium Act claims. When incoming claims are not date-stamped, staff reviewing the claims must use the scan date—which, in many cases, may be an incorrect record of when the claim was received—to determine whether non-VA providers submitted Millennium Act claims before the timely filing deadline.

At the four VA facilities we visited, we found a total of 15 claims that were considered and denied under the Millennium Act that should have been considered under a different payment authority, specifically, service-connected emergency care (6 claims) or preauthorized care (9 claims). Only claims for emergency care not related to veterans' service-connected disabilities should be considered for payment under the Millennium Act. However, we found the following:

- **Claims for service-connected conditions incorrectly categorized.** For six claims—including one from the Black Hills VA Health Care System, two from the North Texas VA Health Care System, two from the Washington DC VA Medical Center, and one from the White River Junction VA Medical Center—nonclinician fee basis staff denied payment after incorrectly categorizing claims that were related to veterans' service-connected disabilities or failing to recognize that veterans had service-connected disabilities before they denied the claims under Millennium Act administrative or clinical criteria. This occurred because VA's policy regarding determinations of whether emergency care claims are related to veterans' service-connected disabilities is unclear. Currently, the policy does not specify that Millennium Act administrative and clinical criteria should be applied to claims only after a clinician has determined that the care was not related to any service-connected disability.
- **Claims not categorized correctly as preauthorized care.** For nine claims—including three from the Black Hills VA Health Care System, one from the Washington DC VA Medical Center, and five from the White River Junction VA Medical Center—fee basis staff denied payment because they did not recognize that these claims were for care that had been preauthorized by VA. This occurred because VA clinicians made non-VA care referrals but failed to follow VA's policy of documenting the referrals in VA's electronic medical record. As a result, fee basis staff were not alerted to create authorizations for the

referrals in FBCS.²⁴ In one case we reviewed, fee basis staff at that VA facility did not have access to any authorizations in FBCS that had been issued by other VA facilities and did not know, when the non-VA provider mistakenly submitted the claim to the nearest VA facility, that a VA clinician from a different VA facility had referred the veteran to the non-VA provider.

The 15 instances we identified where fee basis staff at the four VA facilities we visited made incorrect determinations about whether claims should have been considered for payment under the Millennium Act or another payment authority demonstrate that VA facilities are at risk for inappropriately denying veterans' fee basis claims by applying the wrong payment criteria. These findings also raise concerns about the extent to which this may be occurring at other VA facilities nationwide.

Claims Were Not Routed to the Correct VA Facility for Consideration

At two of the four VA facilities we visited, we found examples of denied Millennium Act claims that had not been routed to the correct VA facility. VA regulations specify that Millennium Act emergency care claims should be reviewed by the VA facility located nearest to where the non-VA provider rendered the services.²⁵

For a total of six claims—three from the Washington DC VA Medical Center and three from the White River Junction VA Medical Center—we found that the claims were initially routed to the incorrect VA facility, which delayed their arrival at the correct VA facility. Two of these six claims were not date-stamped by the VA facility that initially received them and were then denied for not meeting the Millennium Act's 90-day filing deadline after they reached the correct VA facility. Because the claims had not been date-stamped, fee office staff at the VA facilities we visited used the scan date recorded at their facility—which was not the

²⁴According to VA Central Office officials, VA has addressed this problem by creating a standardized process for clinicians to document referrals and alert fee basis offices of the need to create authorizations. VA has educated clinicians and fee basis staff about this standardized process and as of November 2013, VA Central Office officials said that the new process had been fully implemented at all VA facilities.

²⁵VA Central Office officials said the reason Millennium Act claims should be routed to the VA facility nearest to where the non-VA provider rendered the services is that the nearest VA facility would be in the best position to address, for example, whether beds were feasibly available at the VA facility at the time the episode of care occurred and whether the VA facility would have been able to accept the transfer of the veteran from the non-VA provider.

date the claim was initially submitted to VA for consideration—to deny the claims for untimely filing.

In addition to the six, we found two claims that were processed and denied by the Washington DC VA Medical Center that should have been rerouted to other VA facilities. In one of those cases, the non-VA provider submitted the claim electronically, and VA's claims system routed it to the incorrect VA facility. The claim was misrouted because electronic claims are automatically sent to the VA facility closest to the veteran's residence—which may not be the correct VA facility to consider a Millennium Act claim, if the veteran received emergency care from a non-VA provider not located near his or her home. VA officials said the agency set up its electronic claims system to automatically route incoming claims to the VA facility closest to the veteran's residence, because most fee basis claims are for preauthorized care, and it is most likely that the VA facility closest to the veteran's residence was the facility that authorized the non-VA care. However, Millennium Act claims must be considered by the VA facility located nearest to where the non-VA provider rendered the services. While VA policy states this, it does not specify the point at which staff processing claims should verify that claims have been sent to the correct VA facility.

The instances we found at two of the four VA facilities we visited where claims were not routed to the correct VA facilities suggest that VA facilities are at risk for inappropriately denying Millennium Act claims. This also raises concerns about the extent to which other VA facilities nationwide may be inappropriately denying claims as well. If a claim is delayed in reaching the correct VA facility—especially if it is not date-stamped—the VA facility that processes the claim may not be able to make an appropriate determination about whether the claim met the Millennium Act's 90-day filing deadline.

Errors Were Made in Determining Veterans' Enrollment and Use of VA Services

For six claims we examined—including three from the Washington DC VA Medical Center and three from the White River Junction VA Medical Center—we found that fee basis staff incorrectly determined that the veterans were not enrolled in the VA health care system or had not received VA care in the previous 24 months. VA policy for reviewing Millennium Act claims states that VA facilities should verify that a patient is not enrolled in the VA health care system or has not used VA health care within the 24 months prior to the episode of emergency care before denying Millennium Act claims. When examining these six claims, however, we found documentation showing that the patients were in fact

veterans who were enrolled or had used VA care within the 24 months prior to the episode of emergency care.

The reasons VA fee basis staff made these errors when denying these claims were not always clear.²⁶ VA policy states that fee basis staff may choose from five different electronic search tools to make determinations about veterans' enrollment and use of VA services. However, only one of those search tools—the Veterans Integrated Service Network Support Service Center (VSSC) Find User search—allows users to obtain information about veterans' enrollment and use of VA services at any VA facility nationwide. In contrast, the other four electronic search tools provide information about enrollment and use of VA services only for veterans who are registered at the VA facility processing the claim.

The instances where fee basis staff at two of the four VA facilities we visited made errors in determining veteran's enrollment and use of VA services—because they relied on electronic search tools that provided incomplete information—indicate that the potential for VA facilities to inappropriately deny Millennium Act claims exists. This also raises concerns that staff at other VA facilities nationwide may have made similar errors. If fee basis staff at VA facilities do not consistently use the VSSC Find User search, they could continue to make incorrect determinations about veterans' enrollment and use of VA services and inappropriately deny Millennium Act claims.

Medical Claims Related to Motor Vehicle Crashes Were Denied without Sufficient Documentation

At two of the four VA facilities we visited—the Black Hills VA Health Care System and the North Texas VA Health Care System—we found a total of two Millennium Act claims related to injuries sustained in motor vehicle crashes that had been denied because VA assumed the veterans had contractual or legal recourse against a third party, in this case, auto insurance.²⁷ However, VA fee basis staff at these facilities had no

²⁶Veterans are typically registered at the VA facility closest to their home. In three of the six claims, on the basis of the home address of the veterans, it appeared that the veterans were not registered at the VA facility that processed the claims, and the fee basis staff used electronic search tools that provided information about enrollment and use of VA services only for veterans who were registered at the facility where they worked. In the other three claims, there was no clear reason why the claims were denied, because the veterans were registered at the VA facility that processed the claims. The VA facilities did not provide reasons these claims were inappropriately denied.

²⁷In these cases, there was also no record that the veteran had other health insurance.

documentation to support this and did not attempt to verify whether auto insurance covered the claims before denying them. In 2010 Congress amended the Millennium Act emergency care benefit to authorize VA to pay the balance of emergency medical claims when a third party is obligated to pay for only a portion of the care, such as when injuries sustained in motor vehicle crashes are not fully covered by auto insurance.²⁸ Therefore, before denying Millennium Act claims related to motor vehicle crashes, VA facilities should verify that (1) auto insurance or another third party covered the claim, and (2) there was no balance if auto insurance or another third party only partially covered the claim.

The fee office manager at one of the facilities told us that the facility routinely denies emergency care claims related to injuries sustained in motor vehicle crashes because state law requires drivers to establish financial responsibility for their vehicles through auto insurance policies or other means, and the VA facility assumes that such claims related to motor vehicle crashes will be covered entirely by auto insurance. However, in that state, the law governing motor vehicle liability requires drivers to cover only injuries they cause to others as a result of crashes for which they are at fault. Fee basis staff cannot determine from a claim or medical records alone whether the veteran or another driver was at fault in the motor vehicle crash or whether the driver who was at fault had auto insurance coverage. Further, the law in that state only requires that auto insurance policies have a minimum of \$30,000 in liability coverage for each injured person, up to a total of \$60,000 per crash, but the average charge for the motor vehicle crash-related claims we reviewed from that facility was more than \$69,000; therefore, the VA facility could still be responsible for paying the balance of some of the claims it denies without documentation of auto insurance coverage.²⁹

Officials from VA Central Office endorsed the practice of denying Millennium Act claims related to injuries sustained in motor vehicle crashes on the basis of third-party liability—without any documentation—in states that have motor vehicle reparations laws. According to these

²⁸Act of Feb. 1, 2010, Pub. L. No. 111-137, 123 Stat. 3495 (2010).

²⁹The average charge of \$69,000 for the motor vehicle crash-related claims we reviewed at this facility is based on all claims we reviewed at that facility that were related to motor vehicle crashes, including the one claim we identified that had been denied because the VA facility assumed that the claim was covered by auto insurance, as well as the claims that had been denied for other reasons.

officials, it is the veteran's responsibility to show that all possible avenues for payment have been exhausted before VA can pay a Millennium Act claim.

When we examined the standard letter that was sent to one of the veterans with a denied Millennium Act claim related to a motor vehicle crash, we found that it did not clearly state that the claim was denied under the assumption that auto insurance fully covered it, or that the denial could be overturned if the veteran proved that there was no auto insurance coverage for the crash or that auto insurance did not fully cover the medical claim.³⁰ (See app. II for a copy of this letter.)

VA does not require its facilities to document that claims related to motor vehicle crashes were covered entirely by auto insurance before denying them, and VA does not require facilities to inform veterans that VA has the authority to pay the balance of medical claims that are not fully covered by a third party. The instances we identified where two of the VA facilities we visited denied claims related to motor vehicle crashes under the assumption that they were covered entirely by auto insurance—without any documentation of that coverage—suggest that staff at these VA facilities may be inappropriately denying payment for Millennium Act claims related to motor vehicle crashes. This also raises concerns that similar inappropriate denials may be occurring at other VA facilities nationwide.

Selected VA Facilities Did Not Consistently Notify Veterans about Millennium Act Claim Denials and Their Appeal Rights

VA policy states that VA must notify veterans in writing about denied claims and their appeal rights, but many of the Millennium Act claims we reviewed lacked documentation showing that the VA facility notified veterans that their claims had been denied. Table 5 shows the number of denied Millennium Act claims we reviewed at each VA facility for which VA lacked documentation of veteran notification. Claims lacked documentation of veteran notification when (1) the FBCS claim history did not indicate that a veteran denial letter was printed and the VA facility could not produce a copy of a veteran denial letter or (2) the FBCS claim history indicated that a veteran denial letter was printed but there were

³⁰In the other case where the VA facility denied a Millennium Act claim related to a motor vehicle crash under the assumption that the claim was covered by auto insurance, there was no evidence that the VA facility sent a letter to notify the veteran of the denial.

possible technological errors that resulted in no letter being printed because VA could not produce a copy of a veteran denial letter.

Table 5: Denied Millennium Act Claims Lacking Documentation that the Veteran Was Notified of Denial and Appeal Rights, at Four Selected VA Facilities

VA facility	Number of denied Millennium Act claims lacking documentation veteran letter was printed ^a (percentage of sample)	Number of denied Millennium Act claims with possible errors in printing letters ^b (percentage of sample)	Total number of denied Millennium Act claims reviewed
Black Hills VA Health Care System	2 (6%)	3 (9%)	34
North Texas VA Health Care System	15 (47%)	8 (25%)	32
Washington DC VA Medical Center	30 (100%)	0 (0%)	30
White River Junction VA Medical Center	4 (13%)	21 (66%)	32

Source: GAO analysis of Millennium Act claims.

^aThe Fee Basis Claims System (FBCS) claim histories did not indicate that veteran letters were printed, and the VA facilities could not produce copies of any letters notifying the veterans of the denials and appeal rights.

^bThe FBCS claim histories indicated that veteran letters were printed, but the VA facilities could not produce copies of the letters.

FBCS users must remember to periodically print veteran letters for denied Millennium Act claims because the system does not automatically print these letters, nor does it prompt users to print these letters after claims have been denied. Instead, veteran letters for denied claims collect in electronic queues organized by each non-VA provider, and FBCS users must periodically print the veteran denial letters that have collected in the queues.³¹

³¹The process for printing the letters has two steps. First, FBCS users must prompt FBCS to generate images of the letters, and then FBCS users must send the letters to a printer. According to VA Central Office officials, when users prompt FBCS to generate images of the veteran denial letters, notes are automatically added to the FBCS claim histories for those claims indicating that the veteran letter has been printed, whether or not the step of printing the letters is actually completed. After letters are printed, staff at VA facilities must place them in envelopes and mail them to the veterans. For the purposes of this report, we assumed that VA facilities mailed denial letters to veterans in cases where the FBCS claim history indicated that veteran letters were printed and the VA facilities were able to produce copies of the letters showing the date they had been printed. We had no means for confirming that the printed letters had actually been mailed or of verifying that veterans received the letters.

Officials from VA Central Office were unsure why some of the VA facilities we visited were unable to produce copies of veteran denial letters in all cases where the FBCS claim history indicated that a letter had been printed. These officials acknowledged that technological errors in FBCS can occur that could cause FBCS to fail to print veteran denial letters. For example, the officials explained that if there are too many letters waiting to be printed in FBCS, the system can become overloaded and fail to generate images and print the letters. In these cases, the FBCS claim history may still indicate that a letter was printed. VA Central Office officials said that such errors could occur when an FBCS user tries to print a large volume of veteran letters at one time.

The lack of documentation for many of the claims we reviewed at the four VA facilities we visited suggests that the four VA facilities we visited did not notify some veterans that their Millennium Act claims were denied and of their rights to appeal these denials. If similar situations are occurring at other VA facilities nationwide, where veterans are not informed of Millennium Act claim denials or of their appeal rights, and the claims have been inappropriately denied, then veterans could become financially liable for emergency care that VA should have covered.

VA Lacks Sufficient Oversight Mechanisms and Data to Ensure that VA Facilities Do Not Inappropriately Deny Millennium Act Claims

Both VA Central Office and local VA facility oversight have weaknesses, and as a result, VA facilities are at risk for inappropriately denying Millennium Act claims. Oversight activities conducted by VA Central Office and VA facilities do not focus on compliance with applicable requirements, and VA cannot ensure that any deficiencies relating to Millennium Act claims processing identified during field assistance visits are corrected because VA conducts limited follow-up with VA facilities. Moreover, there is a lack of sufficient data for monitoring the appropriateness of Millennium Act claim denials.

Oversight Does Not Focus on the Appropriateness of Millennium Act Claim Denials, and VA Central Office and VA Facilities Cannot Ensure that Deficiencies are Corrected

VA Central Office's and VA facilities' efforts to oversee Millennium Act claims processing do not focus on the appropriateness of Millennium Act claim denials for the following reasons: (1) VA Central Office's annual field assistance visits do not examine all practices at VA facilities that could lead claims to be inappropriately denied; (2) VA facilities do not systematically audit denied Millennium Act claims to ensure that they were denied appropriately; and (3) VA Central Office does not hold VA facilities accountable for correcting deficiencies it identifies during field assistance visits. According to the federal internal control standard for monitoring, agencies should assess the quality of performance over time

Appropriateness of Millennium Act Claim Denials Is Not Addressed During Field Assistance Visits

and provide reasonable assurance that deficiencies are detected and promptly resolved.³²

According to VA Central Office, one of its primary methods for monitoring VA facilities' processing of fee basis claims, including Millennium Act claims, is conducting field assistance visits. In fiscal year 2013, VA Central Office conducted field assistance visits at 30 VA facilities.³³ Sites were selected for review and evaluated mainly on the basis of their timeliness in processing claims and less on the appropriateness of claim denials.³⁴ For example, one of the VA facilities we visited was considered by VA Central Office to be one of the 10 best performing among its facilities because of its timeliness in processing claims, and therefore was not chosen for a field assistance visit in fiscal year 2013. However, our review of a sample of denied Millennium Act claims at this facility showed that fee basis staff were not complying with numerous policies for processing Millennium Act claims, which resulted in some claims being inappropriately denied and some veterans not being notified that their claims had been denied.

On field assistance visits, VA Central Office uses a checklist to guide their observations of VA facilities' fee basis claims processing, but the checklist does not examine all the practices we identified that could lead facilities to inappropriately deny Millennium Act claims.³⁵ For example, while the checklist includes a step relating to whether fee basis claims are date-stamped when they are received, it does not include steps for checking whether all fee basis staff who process Millennium Act claims consistently use the VSSC Find User search to determine if veterans are enrolled at

³²See [GAO/AIMD-00-21.3.1](#).

³³As of October 2012, there were 140 VA facilities that processed fee basis claims.

³⁴VA Central Office selected the 30 lowest-performing facilities for field assistance visits based on the following measures: percentage of claim line items that are paid within 30 days of receipt, percentage of claims that are processed (paid, denied, or rejected) within 30 days of receipt, and percentage of claims awaiting processing that were received fewer than 30 days ago.

³⁵VA Central Office's field assistance checklist for the fiscal year 2013 field assistance visits included 71 steps that related to the financial, clinical, administrative, and organizational functions of fee basis offices at VA facilities. The checklist applied to the processing of all fee basis claims, including Millennium Act claims, preauthorized claims, and claims for emergency care related to service-connected conditions.

Appropriateness of Millennium Act Claim Denials Is Not Systematically Audited at Selected VA Facilities

other VA facilities and whether they have been seen by providers at other VA facilities in the last 24 months.

None of the fee basis managers at the four VA facilities said that they had put systematic procedures in place to audit samples of denied Millennium Act claims to ensure that staff complied with VA policies when they denied the claims and to ensure that Millennium Act claims are not inappropriately denied. VA Central Office officials said they have recommended but not required that fee basis managers at VA facilities audit samples of processed fee basis claims—including claims that have been approved for payment and claims that have been denied—to determine whether staff processed claims appropriately. However, VA Central Office does not know how many VA facilities conduct such audits. In addition, VA Central Office’s internal controls procedure guide for fee basis managers, which outlines the process by which fee managers are expected to help ensure compliance with VA policies, does not specifically communicate fee basis managers’ responsibilities for auditing the appropriateness of fee basis claim denials. Without systematic audits of the appropriateness of fee basis claims decisions, VA Central Office cannot adequately assess the performance of VA facilities in processing fee basis claims—including Millennium Act claims.

VA has implemented automated processes for auditing payments of approved fee basis claims—including Millennium Act claims—to ensure that VA facilities applied the correct payment rates and that no duplicate versions of the claims have already been paid. However, VA has no systemwide process for auditing the appropriateness of decisions made by fee basis staff to approve or deny fee basis claims.

One way that VA facilities could systematically audit the appropriateness of Millennium Act claim denials, in keeping with the federal internal control standard for monitoring, would be to include performance standards relating to the appropriateness of claims decisions in performance appraisal plans for fee basis staff. Such standards would help VA hold fee basis staff accountable for following VA policies and allow supervisors through these audits to identify staff that need additional training. At the time we visited the four VA facilities, none had implemented staff performance appraisal plans that included performance standards relating to the appropriateness of claims decisions. Three of the four facilities indicated that they planned to include such standards in future performance appraisal plans for fee basis staff, but only two of the VA facilities had draft performance appraisal plans at the time we visited. When we reviewed those two draft plans, we found that they included

VA Facilities Are Not Held
Accountable for Correcting
Claims Processing
Deficiencies Identified During
Field Assistance Visits

performance standards relating to appropriateness of claims decisions, but neither of the draft plans specified whether the samples of fee basis claims reviewed would include both approved and denied claims, how the samples would be selected, or whether the samples would include certain percentages of Millennium Act claims and other types of fee basis claims.

Even though VA Central Office informs VA facilities of deficiencies that are identified during field assistance visits, and VA Central Office officials conduct some follow-up with the VA facilities to determine how the facilities address deficiencies, VA Central Office does not hold VA facilities accountable for correcting deficiencies identified through field assistance visits. When VA facilities respond with self-reported actions taken to address the deficiencies, VA Central Office has no process for validating facilities' proposed actions. VA Central Office officials said that field assistance visits are meant to be consultative in nature to assist VA facilities in improving their fee basis claims processing.

Data we obtained on field assistance visits in fiscal years 2012 and 2013 confirm VA's current oversight weaknesses in this regard. In fiscal year 2012, for example, one of the facilities VA visited was not making timely entries in FBCS of authorizations for referrals—a practice that, if not followed, could lead to the inappropriate denial of preauthorized fee basis claims using inapplicable Millennium Act criteria, as we observed in our review of claims.³⁶ VA Central Office observed this deficiency again in fiscal year 2013, even though the facility reported to VA Central Office that it had resolved the problems after the fiscal year 2012 field assistance visit. In another instance, we visited another VA facility approximately a year after its fiscal year 2012 field assistance visit and observed deficiencies that the facility and VA Central Office indicated had been fully resolved after the fiscal year 2012 field assistance visit. For example, one deficiency was related to the VA facility's ability to promptly scan incoming fee basis claims—a practice that could lead to the inappropriate denial of Millennium Act claims, as we had observed in our review of claims—and the other deficiency was related to the VA facility's failure to promptly notify veterans that their claims have been denied.³⁷ These findings raise concerns that VA facilities do not resolve identified deficiencies, as required by the federal internal control standard for

³⁶This is not one of the four VA facilities we visited for this study.

³⁷This VA facility was not selected for a field assistance visit in fiscal year 2013.

monitoring, and VA Central Office may not be able to rely on facilities' self-reported actions taken to correct deficiencies.

VA Central Office officials said they are planning to implement virtual audit teams, which, according to officials, would strengthen their oversight of fee basis claims processing. The officials said that VA facilities would be required to create action plans to address the findings of virtual audits, and facilities would be required to resolve deficiencies. However, VA Central Office's written plan for the virtual audit teams indicates that they will only be auditing the appropriateness of claims decisions for claims that were paid, and it does not outline a process for independently validating facilities' self-reported actions taken to correct deficiencies.

Sufficient Data Needed to Monitor Appropriateness of Denials of Millennium Act Claims Are Lacking

VA Central Office lacks sufficient data to monitor the appropriateness of Millennium Act claim denials because (1) VA has not required VA facilities to adhere to a uniform set of denial reasons in FBCS—thereby impeding a consistent evaluation across VA facilities—and (2) reports submitted to VA Central Office by the facilities mainly focus on timeliness, rather than whether the facilities correctly applied VA policies in denying claims.

In analyzing fiscal year 2012 Millennium Act claims that were denied by the four VA facilities we visited, we found no standardized, uniform set of Millennium Act denial reasons in FBCS. The lack of a standardized set of Millennium Act denial reasons in FBCS impedes VA Central Office's ability to monitor VA facilities' processing of these claims. According to the federal internal control standard for information and communications, agencies should ensure that management has access to the data it needs to carry out its oversight responsibilities.³⁸ Without a uniform set of Millennium Act denial reasons in FBCS, VA Central Office lacks data that would allow the agency to

- track patterns in VA facilities' Millennium Act claim denials,
- identify potential areas of noncompliance in VA facilities' processing of Millennium Act claims, or

³⁸See [GAO/AIMD-00-21.3.1](#).

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- identify areas where communications for veterans and non-VA providers about the Millennium Act emergency care benefit could be improved.

VA Central Office has not established a standardized list of denial reasons for VA facilities to use in FBCS; rather, VA Central Office allows VA facilities to create their own lists of Millennium Act denial reasons in FBCS.³⁹ While there are only 10 administrative and clinical criteria under which Millennium Act claims can be denied, each of the four VA facilities we visited had more than 10 denial reasons represented among the Millennium Act claims they denied in fiscal year 2012; in fact, one of the facilities had 75 different denial reasons.

Moreover, in some cases, the FBCS denial reasons created by individual VA facilities are not aligned with Millennium Act administrative and clinical criteria and may not be valid reasons to deny Millennium Act claims. For example, at all four of the VA facilities, “not authorized” was a possible Millennium Act denial reason in FBCS. This denial reason lacks specificity and would not be a sufficient reason on its own to deny a Millennium Act claim, because Millennium Act claims are, by definition, claims for emergency care that was not preauthorized by VA. In order for a denial of a Millennium Act claim to be valid, the individual processing the claim would have to select an additional denial reason in FBCS that was aligned with one of the Millennium Act administrative or clinical criteria. However, in our review of claims from each of the four VA facilities we visited, we found examples of claims that were denied for “not authorized,” without any other valid Millennium Act denial reason.

At the four VA facilities, we also found multiple variations in the way denial reasons were expressed in FBCS for certain Millennium Act administrative and clinical criteria. For example, one facility had denial reasons of “veteran has other 3rd party insurance” and “veteran has other insurance,” and, according to the facility, both indicated that the veteran had access to coverage under another health plan. This data fragmentation makes it challenging for VA Central Office and the facilities to determine the most frequent or infrequent denial reasons for

³⁹VA Central Office officials said they submitted a request to the contractor responsible for making changes to FBCS to standardize the Millennium Act denial reasons about 4 years ago, but the contractor has yet to implement the enhancement because of competing priorities.

Millennium Act claims, compare patterns in Millennium Act claim denials within and across facilities, and identify potential areas where communications with veterans or non-VA providers could be improved. For example, without data indicating the reasons that Millennium Act claims are most frequently denied, VA Central Office and VA facilities are unable to target communications to better inform veterans and non-VA providers about the Millennium Act eligibility criteria related to those reasons.

VA Central Office's oversight efforts are further impeded because the monthly reports officials rely on to monitor VA facilities' performance in processing Millennium Act claims—called stoplight reports—focus on timeliness, rather than the appropriateness of VA facilities' denial of such claims.⁴⁰ For example, the only aspect of the monthly reports that relates to the appropriateness of claim denials is a tally of the instances in which veterans sought assistance from VA facilities with resolving adverse credit history reports resulting from unpaid fee basis claims. VA facilities are required to report the number of instances where the adverse impact to the veteran's credit history was determined to be the fault of VA, such as cases where the VA facility did not process the fee basis claim in a timely manner. This measure may give VA Central Office some insight about the extent to which VA facilities processed fee basis claims inappropriately; however, since this measure is not specific to the type of fee basis claim, VA Central Office has no way to determine how many cases are related to Millennium Act claims. Because the facilities' monthly reports lack robust data about the appropriateness of Millennium Act claims processing, VA Central Office is limited in its ability to carry out the oversight responsibilities described in the federal internal control standard for information and communications.

⁴⁰These reports contain data relating to the quantity of fee basis claims processed, the timeliness of claims processing, and fee basis claims expenditures. The data in these reports relate to all types of fee basis claims VA facilities process, including Millennium Act claims, preauthorized claims, and emergency care claims related to service-connected conditions.

Despite VA Efforts, Veterans Lack Knowledge about Millennium Act Eligibility, and Selected Non-VA Providers Report Communication Challenges with VA Regarding Millennium Act Claims

VA employs a number of methods to educate veterans regarding their Millennium Act eligibility; however, VA officials, providers, and others we interviewed reported that most veterans with whom they interact have limited knowledge of their eligibility. Similarly, despite VA's efforts, all four non-VA providers we interviewed cited problems in their communications with VA regarding Millennium Act emergency care claims processing.

Veterans Often Have Limited Knowledge Regarding Millennium Act Eligibility

Currently, according to VA officials, VA educates veterans regarding Millennium Act eligibility through patient orientation sessions, during which emergency care benefits are typically covered, and written materials, such as the VA Health Care Benefits Overview 2012, the Veterans Health Benefits Guide, and the Veteran Health Benefits Handbook.⁴¹ Also, if veterans have specific questions about emergency care, they may also contact VA's toll-free number for health care related questions (877-222-VETS), the patient advocate at a VA facility, the fee basis office at a VA facility, or veterans service organizations, according to VA officials. Finally, in response to requests made by veterans service organizations that were concerned about veterans' lack of knowledge about VA emergency care eligibility, VA Central Office mailed a letter and a fact sheet in March 2013 to all enrolled veterans informing them of how emergency care from non-VA providers may be covered, according to VA

⁴¹In 2012, VA personalized the Veteran Health Benefits Handbook for veterans based on their priority group and eligibility, including eligibility guidelines for non-VA emergency care. According to VA, as of December 2013, the agency had mailed over 7.5 million personalized handbooks and continues to mail handbooks to all new enrollees. The Veteran Health Care Benefits Overview 2012 is available at VA facilities and online, while the Veteran Health Benefits Guide is only available online, and will be discontinued and replaced by a new Veteran Health Care Benefits Overview in the future. In addition, in some cases, VA facilities may produce their own pamphlets regarding the Millennium Act benefit and make them available within the facility.

officials. This fact sheet is also available on VA Central Office's National Non-VA Care Program website.

Despite VA's efforts, VA officials from the four facilities we visited—including benefits and enrollment officials, patient advocates, and fee basis officials—non-VA providers, and national representatives of veterans service organizations we interviewed commonly reported that most veterans with whom they had come into contact are not knowledgeable about the Millennium Act or the circumstances under which a Millennium Act emergency care claim can be paid.⁴² For example,

- A veteran may not understand what constitutes an emergency as defined by the Millennium Act and may expect that care at a non-VA provider for a condition he or she considers requires immediate attention will be covered regardless of whether it meets the prudent layperson standard for an emergency condition.
- A veteran who has been admitted to a non-VA hospital may not be aware that he or she should be transferred to a VA facility once stable. Under the Millennium Act, VA will reimburse the non-VA hospital only to the point at which the veteran is stable enough to be transferred.
- Veterans often are not aware of specific eligibility criteria and assume that VA will cover their non-VA emergency care automatically because they perceive it as an entitlement. For example, we reviewed one Millennium Act-related Board of Veterans' Appeals case in which the veteran contended that he was entitled to VA payment for his non-VA emergency care, despite the fact that he did not meet the statutory eligibility requirements of having been seen at VA in the 24 months prior to his emergency episode of care and having no entitlement to care under a health plan contract.⁴³ Furthermore, he argued that he

⁴²A 2011 study of veterans at non-VA emergency departments also found that that some veterans may not be knowledgeable about their eligibility for VA health care coverage, including Millennium Act coverage. For example, the study found that 13 percent of veterans interviewed had no knowledge of their VA health care eligibility in general. S. M. Schneider, T. Richardson, W. Triner, et al., "Use of Non-Veteran Administration Medical Emergency Departments by Military Veterans." *Annals of Emergency Medicine*, vol. 58, no. 4S (2011): 236.

⁴³As of December 2013, according to a facility official, the Board of Veterans' Appeals had not yet made a final decision regarding this case.

should have been notified by VA that he needed to be seen every 24 months to be eligible for Millennium Act coverage.

Furthermore, VA patient advocates and patient benefits and enrollment officials from the facilities we visited and representatives of a veterans service organization said that veterans typically seek information about VA's coverage of emergency care received from non-VA providers after an episode of emergency care occurs, at which point the veteran has missed the opportunity to make more informed health care decisions.

Veterans' lack of knowledge of Millennium Act eligibility criteria can have a potential negative impact on their ability to gain accessible and timely health care. VA officials we interviewed were aware of specific recent cases where veterans delayed or avoided seeking treatment at local non-VA providers to go to a VA facility instead.⁴⁴ For example,

- two patient advocates we interviewed cited a case where the wife of a veteran who had gunshot wounds drove him to a VA facility about 30 miles away, bypassing a number of other non-VA emergency departments,
- a VA Central Office official described an account involving a veteran experiencing chest pains who drove over 100 miles to a VA facility rather than going to the nearest emergency department, and
- another VA Central Office official cited a case where a veteran experiencing chest pains died during a weekend as he waited to seek care until the local VA community-based outpatient clinic opened on Monday.

Concerns about veterans' access to care were expressed more broadly in a 2011 academic study of VA patients, providers, and staff at Midwestern VA primary care clinics. During the study, patients, providers, and staff all expressed concerns that veterans delay or avoid seeking emergency care at non-VA providers because they are not sure VA will cover their costs.⁴⁵ One VA patient interviewed as a part of the study reported that his wife

⁴⁴Representatives of veterans service organizations we interviewed were not aware of or did not report any recent cases where veterans delayed or avoided seeking treatment at local non-VA providers to go to a VA facility instead.

⁴⁵C. Buzza, S. S. Ono, C. Turvey, et al., "Distance is Relative: Unpacking a Principal Barrier in Rural Healthcare." *J Gen Intern Med*, vol. 26, suppl. 2 (2011):648–54.

called VA while he was experiencing a heart attack, explaining that he had no insurance and they were not sure where to go. The couple was instructed to go to the nearest emergency room; however, VA later denied payment for the emergency care, and the couple was responsible for paying the associated costs. Another VA patient interviewed as part of the study, who lives 140 miles from the nearest VA medical center, cited the distance as a factor that had prevented him from seeking care during an emergency.

Given the outreach and education efforts VA has already put forward for veterans regarding Millennium Act eligibility requirements, we found no clear reasons why veterans still may be unaware of these requirements. Based on our discussions with officials from VA facilities and others, we did, however, identify several contributing factors. Following are examples.

- When we reviewed the March 2013 fact sheet covering Millennium Act benefits and eligibility that VA sent to enrolled veterans, we found that it did not list all the Millennium Act criteria. When we asked about this, VA Central Office officials said that the primary intent of the letter and fact sheet was to communicate the importance of promptly seeking care from the nearest emergency department and discourage veterans from delaying care or bypassing non-VA providers in the event of an emergency. The officials said that VA did not include all the Millennium Act criteria in the letter and fact sheet because they believed this might overwhelm veterans, raise veterans' anxiety about whether VA will cover their care, and discourage them from seeking medical attention from non-VA providers in an emergency.
- VA patient benefits and enrollment officials with whom we spoke at two of the four facilities said that patient orientation sessions cover emergency care benefits for veterans; however, these sessions are generally not well-attended.
- Although one objective in VA's fiscal year 2011-2015 strategic plan is to educate and empower veterans and their families through more outreach and more effective advocacy efforts, VA facility officials we interviewed reported that their facilities have not conducted any veteran evaluations to determine where gaps in information about health care benefits exist, including about Millennium Act eligibility,

and VA Central Office does not require any facilities to do so.⁴⁶ As a result, VA is not fully aware of the gaps in veterans' knowledge regarding Millennium Act eligibility. According to the federal internal control standard for risk assessment, agencies should identify risks that could impede the efficient and effective achievement of agency objectives. Without a complete understanding of veterans' level of knowledge regarding their Millennium Act eligibility, especially given the risks for potentially negative effects on veterans' health and finances as a result of lack of knowledge, VA's potential for accomplishing its strategic objective of improving veteran outreach and advocacy is impeded.

VA officials and national representatives of veterans service organizations we interviewed had some suggestions for improving veteran knowledge of Millennium Act emergency care coverage. For example, they suggested improving the clarity of Millennium Act eligibility criteria in written materials so veterans could more easily grasp the requirements and requiring veterans to attend orientation sessions upon enrollment.

Selected Non-VA Providers Reported Communication Challenges with VA Regarding Claims

Officials from four non-VA providers we interviewed cited instances of communications problems with VA about Millennium Act claims. Poor communication issues included the following:

- **Point of contact at VA not designated.** Two of the non-VA providers said they did not have a specific point of contact at their VA facilities who could answer concerns and issues about Millennium Act claims, leading to potential issues relating to resolving questions about Millennium Act claims in a timely manner.
- **Delays in claims processing.** Billing officials at one non-VA hospital said they often received no response after claims were sent to VA or experienced lengthy delays in the processing of their claims, in some cases, years. The officials said they had approached VA in 2008 to try to discuss ways to improve the claims process, but those efforts were unsuccessful.

⁴⁶U.S. Department of Veteran Affairs, *Strategic Plan Refresh Fiscal Year 2011-2015* (Washington, D.C.: n.d.). This objective also includes improving the agency's ability to listen to veterans and their families to learn more about what works best for them and establishing feedback mechanisms for continuous program and service improvement.

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- **Lack of responsiveness when attempting to transfer veterans.** Officials at one non-VA hospital said they had experienced challenges in the past connecting with the inpatient admissions staff at their local VA facility, making it difficult for the non-VA hospital to transfer veterans to the VA facility after veterans were stabilized. According to these officials, the VA facility did not consistently answer calls during business hours or weekends.
 - **Failure to document discussions about potential transfers.** An official from one non-VA hospital cited cases where the hospital had attempted to transfer stable veterans to the VA facility after an episode of emergency care, but the VA facility informed them that it was not able to accept the patient. Later, according to the non-VA hospital officials, the VA facility denied the claims because VA could find no record of any contact with the non-VA hospital regarding the potential transfers.
 - **Lack of electronic process for submitting medical records.** Two of the non-VA providers said that not being able to send medical records electronically to VA presents a challenge in VA's being able to process Millennium Act claims in a timely manner.⁴⁷ For example, officials from one non-VA provider explained that the main VA facility with which it interacts prefers to receive claims electronically; yet, this facility has a difficult time receiving and scanning hard-copy medical records and matching them to the applicable electronic claim in a timely manner.

At the field level, VA facilities communicate with non-VA providers in a number of different ways, according to VA facility officials we interviewed. For example, they have (1) informal, ad-hoc communications between VA fee basis office staff and non-VA providers regarding the status of Millennium Act claims; (2) telephone conversations between VA facility admissions staff and non-VA providers regarding the potential transfer of veterans being treated by non-VA providers; and (3) in some cases, targeted visits to selected non-VA providers to discuss claims processing or other billing issues.

⁴⁷One of the non-VA providers we interviewed had given its closest VA facility remote access to the hospital's electronic medical records so that fee basis staff at the VA facility could more easily process fee basis claims, including Millennium Act claims. This was the only non-VA provider we interviewed that had established such an arrangement with the VA facility in its area.

At the national level, VA Central Office officials said that they have attempted to improve communications with non-VA providers in the last 2 years. Specifically, VA Central Office communicates information to non-VA providers about Millennium Act emergency claims processing in a number of ways, including the following:

- the National Non-VA Care Program website, which provides resources and information about Millennium Act claims processing for non-VA providers;
- an electronic newsletter for non-VA providers, which provides updates and other information regarding fee basis claims processing; and,
- a 2012 letter mailed to all non-VA providers who billed VA in the last 2 years, providing information about VA emergency care eligibility and references to the website and electronic newsletter for more resources.

On the basis of interviews we conducted with officials from four non-VA providers, however, some of VA Central Office's attempts to improve communications regarding Millennium Act claims processing have not reached their intended audience. For example, none of the officials from the four non-VA providers recalled receiving the 2012 letter that VA Central Office sent to non-VA providers, and only two of the four providers were familiar with VA Central Office's National Non-VA Care Program website; of the two non-VA providers, one commented that the information on the website was not useful because it did not contain the information the provider needed. None of the non-VA providers were aware of the electronic newsletter for non-VA providers, and VA Central Office officials acknowledged that a very small percentage of the non-VA providers who bill VA for fee basis care had signed up for the electronic newsletter.

In 2011, VA Central Office conducted a customer satisfaction survey for non-VA providers who had billed VA for any type of fee basis care. The findings of this survey, which had over 400 respondents, further support our finding that non-VA providers have experienced challenges communicating with VA.⁴⁸ There were significant percentages of unfavorable responses to the following customer service-oriented topics included in the survey:

⁴⁸The survey had a response rate of 10 percent.

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- **Access to VA staff for advice and assistance.** More than half of all responses were unfavorable.
 - **Extent to which fee basis staff keep the non-VA provider informed of conditions and changes that affect them.** Almost 60 percent of all responses were unfavorable.
 - **Resolution of problems with minimal effort on the part of the non-VA provider.** More than 80 percent of all responses were unfavorable.
 - **Extent to which problems are resolved quickly.** Nearly 80 percent of all responses were unfavorable.

In addition to the establishment of the website and electronic newsletter noted earlier, according to VA officials, VA Central Office took some steps to improve its overall customer service and communications with non-VA providers after the 2011 survey, such as holding training sessions for VA facility fee basis managers on improving outreach with non-VA providers. VA Central Office recently completed a second round of the non-VA provider customer satisfaction survey in 2013, and saw some improvement in their customer service measures, but overall, significant percentages of unfavorable responses persisted.⁴⁹ According to VA, this survey of non-VA providers is one part of a broader effort, known as the Non VA-Care Coordination Initiative, which the agency is undertaking to improve the health care coordination of veterans who use health care within and outside the VA.

Comments by two non-VA providers suggested that some local efforts by VA facilities had helped to improve claims processing and communications. For example, they reported that VA facilities' claims processing and communications have been enhanced recently because of the consolidation of VA fee basis functions in one location and other efficiency efforts aimed at improving the exchange of information by two of the four VA facilities we visited.

⁴⁹For example, the customer service topic relating to the extent to which fee basis staff keep the non-VA provider informed of conditions and changes that affect them decreased by 13 percentage points, with 45 percent reporting unfavorable responses; the customer service topic relating to the extent to which problems are resolved quickly decreased by 3 percentage points, with 74 percent reporting unfavorable responses. The survey had 586 respondents and a response rate of 6 percent.

Conclusions

The Millennium Act provides critical safety net emergency care coverage for veterans when they do not have insurance and need emergency care that is not related to a service-connected disability. However, weaknesses in VA's administration and oversight of this emergency care benefit have the potential to lead veterans to (1) by-pass the closest non-VA facility in an emergency because of confusion about eligibility and the fear of being held financially liable for expensive medical bills, and (2) financial harm. We identified weaknesses in three main areas that limit VA's ability to effectively administer the emergency care provisions of the Millennium Act.

First, we found significant problems with processing Millennium Act emergency care claims at the four VA facilities we visited. Noncompliance by VA facility staff with applicable requirements to ensure that claims are reviewed correctly—such as date-stamping incoming claims and immediately scanning them into the FBCS, assigning claims to the correct payment authority and ensuring they are routed to the correct VA facility, and ensuring that staff use electronic search tools that provide complete information when staff make determinations about veteran eligibility and use of VA services—has resulted in some claims being inappropriately denied. Also, we are concerned by VA facilities' practice of automatically denying emergency care claims related to motor vehicle crashes because fee basis staff have been instructed to assume that such claims will be covered entirely by auto insurance and by evidence that suggests veterans have often not been notified of their claim denials or rights to appeal. By not complying with applicable requirements for processing Millennium Act claims, inappropriately denying claims, and potentially not informing veterans of denials, VA facilities may make veterans financially liable for emergency care that VA should have covered. If these veterans were unable to pay these claims, their credit ratings may have been negatively affected and they may have faced personal financial hardships. Steps need to be taken to bring VA facilities into compliance with these requirements and prevent veterans from incurring unnecessary financial harm due to inappropriate denial of Millennium Act claims.

Second, we found that VA lacks sufficient oversight mechanisms and data to ensure that VA facilities do not inappropriately deny Millennium Act claims. The agency's oversight activities do not focus on whether claims are denied appropriately and do not require facilities to correct identified deficiencies. Furthermore, VA does not have sufficient data to monitor the appropriateness of Millennium Act claim denials. As a result, VA Central Office has only a partial view of the Millennium Act claims processing picture. The claims we reviewed that were reconsidered and

later paid would not have been identified through oversight mechanisms or data that VA currently has in place. Given these gaps in oversight, VA does not have the information it needs to ensure it is taking actions necessary to correct situations where facilities have erroneously denied Millennium Act claims.

Finally, we found that veterans generally have limited knowledge of their Millennium Act emergency care eligibility, and non-VA providers said they experience challenges in communicating with VA facilities about Millennium Act claims. Effective communication with veterans and between VA and non-VA providers is essential to the appropriate and successful reimbursement of Millennium Act emergency care claims. Veterans' most detailed education about the Millennium Act emergency care benefit typically occurs after the episode of emergency care, at which point the veteran has missed the opportunity to make more informed health care decisions. VA facilities we visited do not conduct veteran evaluations to determine where gaps in information about health care benefits exist, including about Millennium Act eligibility, and VA Central Office does not require any facilities to do so, so VA's ability to target efforts to educate veterans about the emergency care benefit is limited. Given reported instances of veterans bypassing local emergency departments to get to a VA facility and veterans seeking non-VA emergency care who assume it will be covered in situations in which it may not, it is critical that VA identify the gaps in veterans' knowledge about the Millennium Act and better educate and inform veterans regarding their eligibility.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following 12 actions:

- To address VA facilities' compliance with applicable requirements for processing non-VA provider emergency care claims,
 - implement measures to ensure that all VA facilities comply with VA's policy requirement that incoming claims be date-stamped and scanned into FBCS on the date of receipt.
 - clarify policies and guidance for processing Millennium Act claims to specify that clinicians determine whether emergent care is related to a veteran's service-connected disability before other Millennium Act criteria are applied to claims, and implement measures to ensure that all VA facilities comply with this policy.

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- clarify the policy for processing Millennium Act claims to communicate the importance of promptly verifying that claims have been sent to the correct VA facility, and implement measures to ensure that all VA facilities comply with this policy.
 - revise VA policy for processing Millennium Act claims to require that VA fee basis staff who process the claims use the VSSC Find User search to make determinations about veterans' enrollment and use of VA services.
 - establish a VA policy regarding processing Millennium Act claims to require VA facilities to assist the veteran in determining whether a claim is eligible for coverage by auto insurance or another third party before denying the claim; and ensure that the standard letters sent to veterans whose claims are denied because of third-party liability, in this case auto insurance coverage, more clearly communicate that the denial could be overturned if the veteran can prove that auto insurance did not fully cover the claim.
 - To better ensure that veterans are notified of Millennium Act emergency care claim denials, require fee basis supervisors at each VA facility to develop mechanisms for verifying that veteran denial letters are printed and mailed.
 - To improve oversight of Millennium Act claims processing by increasing the focus on determining whether claims are inappropriately denied and ensuring that deficiencies are corrected,
 - revise the scope of field assistance visits to include an assessment of whether fee basis staff are making appropriate decisions about whether Millennium Act claims meet administrative and clinical criteria for payment.
 - require VA facilities to systematically audit the appropriateness of Millennium Act claim approvals and denials by taking actions such as revising VA Central Office's internal controls procedure guide for fee basis managers or by establishing performance measures related to the appropriateness of claim approval or denial decisions for fee basis staff.
 - require VA facilities to correct fee basis claims processing deficiencies that are identified through field assistance visits or virtual audits, once they are implemented, and establish a process for validating facilities' self-reported actions taken to address deficiencies.

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- To improve VA's ability to identify systemwide patterns in denials, areas of noncompliance in VA facilities' processing of Millennium Act claims, and areas where communications for veterans and non-VA providers could be improved,
 - establish a standard set of Millennium Act denial reasons in FBCS that are specific and aligned with the Millennium Act administrative and clinical criteria, and ensure they are consistently applied across VA facilities.
 - establish a regular reporting mechanism through which VA facilities would provide to VA Central Office data related to the appropriateness of decisions to approve or deny Millennium Act claims.
 - To improve VA's ability to address its strategic plan objective of educating and empowering veterans, take steps to better understand gaps in veterans' knowledge regarding eligibility for Millennium Act emergency care, such as by conducting veteran surveys of health care benefits knowledge, and using information from those surveys to more effectively tailor the agency's education efforts regarding the Millennium Act benefit. In conducting these surveys, consideration should be given to including a sample of veterans who have had denied Millennium Act claims in order to provide their views and specific details of their experiences.

Agency Comments and Our Evaluation

VA provided written comments on a draft of this report, which we have reprinted in appendix III. In its comments, VA generally agreed with our conclusions, concurred with our 12 recommendations, and described the agency's plans to implement each of our recommendations. VA also provided technical comments, which we have incorporated as appropriate.

While the draft report was at VA for comment, we had discussions with officials from VA's Chief Business Office for Purchased Care about 5 of the 12 recommendations in the draft report. As a result of these discussions, we have made revisions to five recommendations in this report as described below.

- Three recommendations in the draft report involved VA facilities developing local standard operating procedures to communicate to staff how they should comply with three requirements related to processing Millennium Act emergency care claims:
 - (1) promptly date-stamping and scanning incoming claims,

(2) determining whether emergent care is related to a veteran's service-connected disability before applying Millennium Act criteria, and (3) verifying that Millennium Act claims have been sent to the correct VA facility for processing. VA officials told us that while they agreed that the agency needs to implement measures to ensure that all VA facilities comply with these three requirements, they did not believe that requiring VA facilities to develop local standard operating procedures was the best way to achieve compliance. After these discussions, we decided to remove the establishment of local standard operating procedures at VA facilities from the three recommendations and to instead provide VA the flexibility to implement nationwide measures to ensure that VA facilities comply with requirements for processing Millennium Act claims.

- One recommendation in the draft report involved an enhancement to FBCS that would prompt users to print veteran letters as claims are approved or denied. VA officials explained that they would face challenges in implementing a technological enhancement for FBCS, so we removed this aspect of our recommendation and instead are recommending that VA require fee basis supervisors at each VA facility to develop mechanisms for verifying that veteran denial letters are printed and mailed.
- The fifth recommendation in our draft report that we discussed with VA officials involved VA facilities reporting to VA Central Office data related to the appropriateness of Millennium Act claim decisions through their monthly spotlight reports. VA officials explained that while they agreed with the intent of the recommendation—that VA facilities regularly report data related to the appropriateness of decisions to approve or deny Millennium Act claims—they preferred not to use the spotlight report as the mechanism for collecting these data from VA facilities. We have revised the recommendation to provide VA more flexibility in determining the best mechanism for collecting data from VA facilities on the appropriateness of decisions to approve or deny Millennium Act claims.

Our review of VA's proposed actions to implement the 12 recommendations in this report indicates that these actions are only likely to address 5 of the recommendations, partially address the issues raised in 3 of the recommendations, and not likely to adequately address 4 of the recommendations, as summarized below.

Specifically, we believe that VA's plans, when implemented, would address the following five recommendations.

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- VA stated that to address our first recommendation—to promptly date-stamp and scan incoming claims—it plans to communicate the importance of adherence to these policy requirements through biweekly publications and through teleconferences for fee basis staff. VA also plans to update the checklist used on its field assistance visits and to develop national training to help ensure compliance with these requirements.
 - To address our fifth recommendation, concerning denials of claims related to motor vehicle crashes, VA plans to examine VA facilities' current processes to identify best practices for handling claims related to motor vehicle crashes, consider possible revisions to current policy, and assess the feasibility of modifying the standard letter sent to veterans whose claims are denied because of auto insurance coverage. VA also plans to develop national training to help ensure compliance with requirements for processing Millennium Act claims related to motor vehicle crashes.
 - To address our ninth recommendation—to require VA facilities to correct fee basis claims processing deficiencies that are identified through field assistance visits or virtual audits by establishing procedures for reporting noncompliant VA facilities to VA Central Office leadership for further action—VA stated that the Chief Business Office for Purchased Care will establish procedures for identifying and reporting noncompliant sites.
 - To address our 10th recommendation—to establish a standard set of Millennium Act denial reasons in FBCS that are specific and consistently applied across VA facilities—VA stated that it had previously submitted a request to the VA Office of Information and Technology for an FBCS enhancement, but it was not funded. Instead, VA plans to update its policy, if necessary, and assess the feasibility of locking down a uniform set of denial reasons in FBCS to prevent users at VA facilities from making changes.
 - To address our 12th recommendation—to take steps to better understand gaps in veterans' knowledge regarding their eligibility for the Millennium Act emergency care benefit—VA stated that it plans to identify options for surveying veterans, explore the possibility of promoting veteran education through conferences or town hall meetings organized by veterans service organizations, and review information currently available on VA's websites and update it if necessary.

We believe that VA's plans to address 3 of our 12 recommendations will only partially address some of the areas of noncompliance we identified during our review. Specifically,

- in response to our second recommendation—that VA clarify policies to specify that clinicians determine whether emergent care is related to a veteran's service-connected disability before any Millennium Act administrative or clinical criteria are applied to claims—VA did not indicate that it planned to review or update its policy. VA's current policy does not specify that Millennium Act criteria should be applied to claims only after a clinician has determined that the care was not related to any service-connected disability. In our review of 128 denied Millennium Act claims, we identified claims that were considered and denied under the Millennium Act that should have been considered and potentially could have been paid under different payment authorities. We believe that if VA does not clarify its policies, VA facilities will remain at risk for inappropriately denying claims.
- in response to our third recommendation—that VA clarify its policy to communicate the importance of promptly verifying that Millennium Act claims have been sent to the correct VA facility—VA stated that it would review and update policy if necessary. When we reviewed this policy, we determined that it does not specify the point in the Millennium Act claim review process at which staff processing the claims should verify that they have been sent to the correct facility, and our review of 128 denied Millennium Act claims revealed examples of denied claims that had not been routed to the correct VA facility. If claims are not routed to the correct VA facility in a timely manner, especially if they have not been date-stamped by the facility that initially received them, they could be inappropriately denied for not meeting the Millennium Act's 90-day filing deadline. We continue to believe a clarification of VA's policy could help to address this issue.
- to address our sixth recommendation, regarding veteran notification of claim denial, VA stated that it plans to assess the feasibility of enhancing FBCS to allow notations and dates to be added to claim histories to document when notifications of denial have been printed for non-VA providers and veterans. It is our understanding that FBCS already has the capacity to document the date that these notifications were printed, but our review of 128 denied Millennium Act claims revealed possible errors in printing these notifications because the VA facilities we visited could not produce copies of veteran denial letters in all cases where the FBCS claim histories indicated that letters had

been printed. In light of this technological error, we believe a revision of VA's policies for processing Millennium Act claims to require fee basis supervisors at each VA facility to develop a mechanism to ensure that veteran denial letters are printed and mailed would provide assurance of notification until a technological solution is instituted.

VA's planned actions on the remaining four recommendations do not, in our opinion, adequately address our concerns and will not be sufficient to correct program weaknesses. Specifically,

- in response to our fourth recommendation—that VA revise its policy to require fee basis staff to use the VSSC Find User search to make determinations about veterans' enrollment and use of VA services—VA stated that it would review current policy and update it if necessary. We appreciate VA's commitment to examining this policy, but our review of VA policies and 128 denied Millennium Act claims from four VA facilities revealed that weaknesses in this policy exist, and VA facilities are at risk for inappropriately denying Millennium Act claims. Specifically, we found that current VA policy permits fee basis staff to use electronic search tools that provide incomplete information about veterans' enrollment and use of VA services when they are making determinations about whether claims meet the Millennium Act criteria. We believe that if VA does not revise its policies to clarify for fee basis staff the correct way to process Millennium Act claims, VA facilities will remain at risk for inappropriately denying claims.
- to address our seventh recommendation—to revise the scope of field assistance visits to include an assessment of whether fee basis staff are making appropriate decisions about whether Millennium Act claims meet administrative and clinical criteria for payment—VA indicated that it plans to incorporate additional interview questions in its field assistance visit checklist. While this is a positive step, we believe that the goal of ensuring compliance with applicable requirements would be better achieved by reviewing samples of approved and denied Millennium Act claims, rather than interviewing staff about Millennium Act requirements during field assistance visits, because our interviews with fee basis staff at four VA facilities did not reveal the types of noncompliance we found during our review of denied claims.

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- to address our eighth recommendation—to require VA facilities to systematically audit the appropriateness of Millennium Act claim approvals and denials—VA stated that it has already established a virtual audit process to check paid claims for improper payments. VA's effort to ensure that Millennium Act payment rates are correct is an important goal, but this action does not address our finding that VA facilities were making incorrect determinations about whether Millennium Act claims met the criteria for payment. VA also stated in its comments on this recommendation that it plans to review its internal controls procedure guide for fee basis managers and update it if necessary. When we reviewed this procedure guide, we found that it does not specifically communicate fee basis managers' responsibilities for auditing the appropriateness of fee basis claims decisions; thus, we continue to believe that an update is necessary.
 - to address our 11th recommendation—to establish a regular reporting mechanism through which VA facilities would provide to VA Central Office data related to the appropriateness of decisions to approve or deny Millennium Act claims—VA stated that it would assess the feasibility of tracking and reporting VA facilities' denial and approval reasons for Millennium Act claims. We do not believe that this planned action is responsive to our recommendation, which is intended to improve VA's ability to monitor the performance of its facilities and provide insight about the extent to which VA facilities have made incorrect determinations about whether Millennium Act claims met the criteria for payment. As a result, we continue to believe that a requirement that VA facilities regularly report data related to the appropriateness of Millennium Act claim decisions is necessary to help VA carry out its oversight responsibilities.

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

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

A handwritten signature in black ink that reads "Randall B. Williamson". The signature is written in a cursive style with a large, prominent initial "R".

Randall B. Williamson
Director, Health Care

List of Requesters

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
House of Representatives

The Honorable Karen Bass
House of Representatives

The Honorable Ken Calvert
House of Representatives

The Honorable John Campbell
House of Representatives

The Honorable Lois Capps
House of Representatives

The Honorable Judy Chu
House of Representatives

The Honorable Jim Costa
House of Representatives

The Honorable Susan Davis
House of Representatives

The Honorable Joe Heck
House of Representatives

The Honorable Duncan Hunter
House of Representatives

The Honorable Darrell Issa
House of Representatives

The Honorable Kevin McCarthy
House of Representatives

The Honorable Howard P. "Buck" McKeon
House of Representatives

The Honorable Gary Miller
House of Representatives

The Honorable Grace Napolitano
House of Representatives

The Honorable Dana Rohrabacher
House of Representatives

The Honorable Lucille Roybal-Allard
House of Representatives

The Honorable Ed Royce
House of Representatives

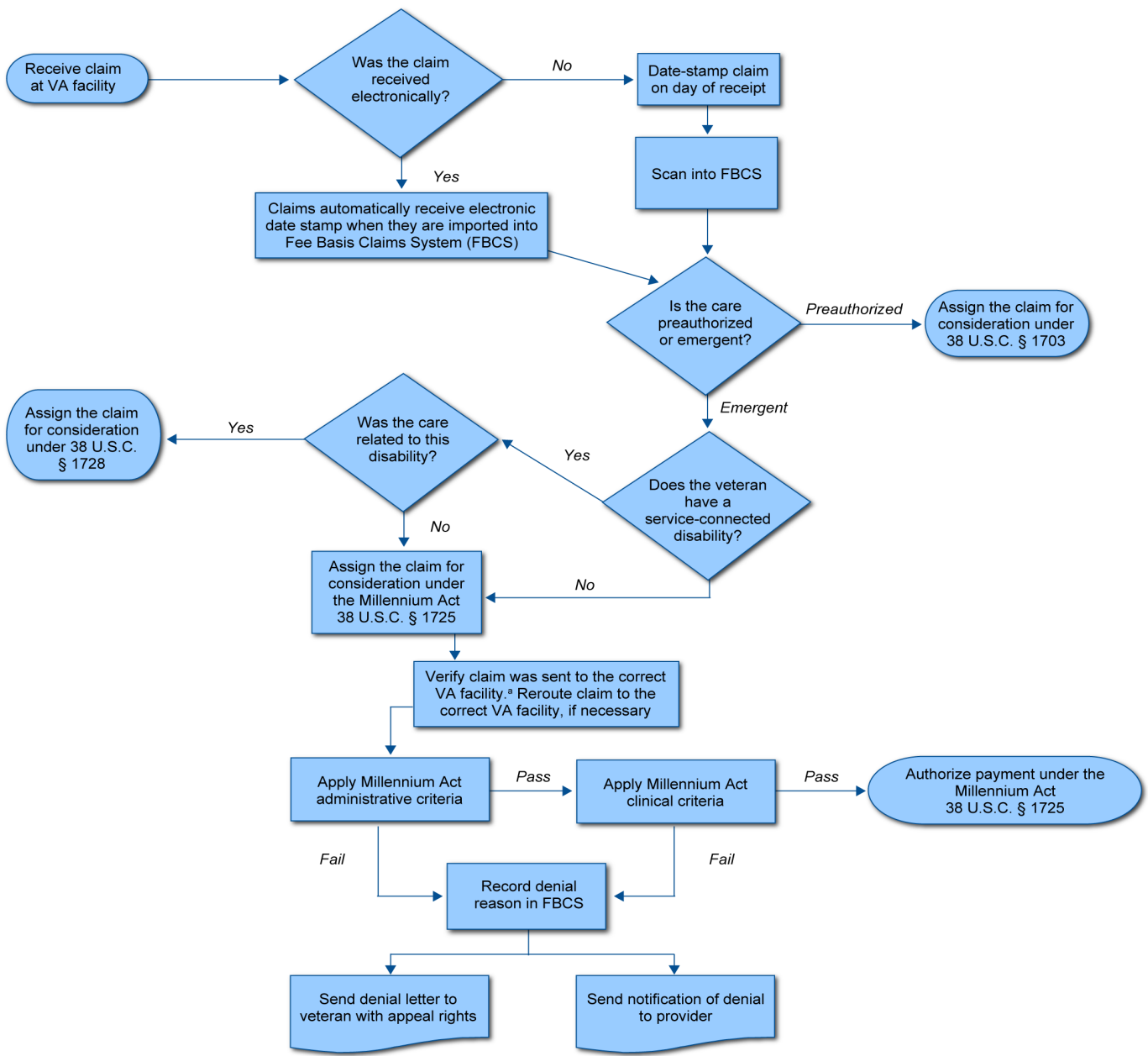
The Honorable Loretta Sanchez
House of Representatives

The Honorable Adam Schiff
House of Representatives

The Honorable Brad Sherman
House of Representatives

The Honorable Henry A. Waxman
House of Representatives

Appendix I: VA's Process for Receiving Fee Basis Claims and Processing Millennium Act Claims



Source: GAO.

^aThe correct VA facility for considering a Millennium Act claim is the facility of jurisdiction—the VA facility geographically located closest to the non-VA provider where the emergency care services were rendered. In cases where the non-VA provider is geographically located closest to a VA community-based outpatient clinic, the Millennium Act claim should be routed to the VA facility responsible for processing that clinic's fee basis claims.

Appendix II: Example of a Standard Veteran Denial Letter for a Claim Related to a Motor Vehicle Crash



DEPARTMENT OF VETERANS AFFAIRS

UB Claim ID#
Fee Program: 1725

Provider:
Episode of Care:

Consideration of possible VA financial assistance has been given your claim under the Veterans Millennium Health Care and Benefits Act, H.R. 2116. We regret to inform you that your claim as been disapproved for the reason listed below:

- The claim is denied due to Veteran has other coverage, insurance, or payer; in whole or part for this date of service.

All claims and charges associated with denied dates of services are also denied.

Payment may only be made if **all 5** of the following criteria are met: (1) veteran is financially liable to the provider for emergency treatment; (2) veteran is enrolled in the VA health care system and received treatment within a 24-month period proceeding emergency care; (3) the veteran has no other coverage under a health plan contract that would pay, in whole or part; (4) VA facilities are not feasibly available and an attempt to use them beforehand would have been hazardous to life or health; and (5) emergency services were provided in a hospital emergency department, a free standing urgent care clinic, or a similar facility held out as providing urgent or emergency care to the public, up to the point of medical stability. The absence of any one of these criteria precludes payment by the US Department of Veterans Affairs.

If you do not agree with the decision made on this claim, you have the right to appeal. VA Form 4107, Notice of Procedural and Appellate Rights is enclosed.

If you have any questions or concerns, please contact us at the above address or you may contact the Fee Services Section at (903) 583-6363

Sincerely,

Attachment: VA Form 4107, Notice of Procedural Appellate Rights

Note: To protect the veteran's privacy, any potentially identifying information was redacted.

Appendix III: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington, DC 20420

February 10, 2014

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

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA HEALTH CARE: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit**" (GAO-14-175). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's 12 recommendations in the draft report, provides an action plan for each, and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink, appearing to read "Jose D. Riojas".

Jose D. Riojas
Chief of Staff

Enclosure

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Department of Veterans Affairs (VA) Response to
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(GAO-14-175)

**We recommend that the Secretary of Veterans Affairs direct the Under Secretary
for Health:**

**To Address VA facilities' compliance with applicable requirements for processing
non-VA provider emergency care claims:**

**Recommendation 1: Implement measures to ensure that all VA facilities are
complying with VA policy's requirement that incoming claims be date-stamped
and scanned into FBCS on the date of receipt.**

VA Comment: Concur. The Veterans Health Administration's (VHA) Chief Business
Office Purchased Care (CBOPC) will:

- Create an article in the CBOPC bi-weekly publication titled *The Bulletin* reminding VA Medical Centers (VAMC) to scan or date stamp incoming claims in order to comply with current national operating guidelines for scanning and date-stamping claims. *The Bulletin* provides articles to National Non-VA Medical Care Program Offices (NNPO) regarding audits, the State Home Grant and Per Diem program, the Fee Basis Claims System (FBCS), policy issues, and various other issues. Anticipated completion date: March 31, 2014.
- Reiterate applicable policy on the NNPO national call in February 2014 and the next quarterly Veteran Integrated Service Network (VISN) Business Implementation Managers (BIM) call. Anticipated completion date: March 31, 2014.
- Review and update the Field Assistance (FA) checklist to ensure VA facilities are complying with the national guidelines for the daily scanning of claims into FBCS. Anticipated completion date: March 31, 2014.
- Develop training focused specifically on Millennium Act claims. The training will address recommendations 1, 2, 3, and 5. Anticipated completion date: November 15, 2014.

**Recommendation 2: Clarify policies and guidance for processing Millennium Act
claims to specify that clinicians determine whether emergent care is related to a
veteran's service-connected disability before other Millennium Act criteria are
applied to claims, and implement measures to ensure that all VA facilities comply
with this policy.**

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VA Comment: Concur. National standardized optimization processes currently require that administrative and clinical eligibility be completed first to determine the appropriate Federal authority under which the non-VA emergent claim will be processed. If the Veteran has a rated service-connected (SC) disability, the claim meets the administrative eligibility criteria, and the emergent treatment has been determined to be directly related to, or adjunct to, the SC disability, the claim would lend itself to 38 U.S.C. 1728 and would not be processed under the Millennium Act, 38 U.S.C. 1725. If the claim cannot be paid under 38 U.S.C. 1728, VA will consider the claim under 38 U.S.C. 1725. If the claim meets the administrative eligibility criteria for 38 U.S.C. 1725, the non-VA emergent care claim will be forwarded for clinical review and adjudication. Please note the initial administrative review allows for the request of additional information to include clinical documentation, if needed, and confirmation that the correct criteria are met prior to requesting a clinical review.

CBOPC will raise awareness of current processes by:

- Creating and publishing an article in the CBOPC bi-weekly publication titled *The Bulletin* and reference current national policy and related procedure guides. Anticipated completion date: March 31, 2014.
- Making an announcement on the NNPO national call in February 2014 and the next quarterly VISN BIM call to clarify policies and guidance for processing Millennium Act claims and to specify roles to determine clinical eligibility. Anticipated completion date: March 31, 2014.
- Evaluating site clinical review and documentation processes as part of FA site visits and updating FA interview questions to ensure compliance with this process. Anticipated completion date: March 31, 2014.

Recommendation 3: Clarify the policy for processing Millennium Act claims to communicate the importance of promptly verifying that claims have been sent to the correct VA facility, and implement measures to ensure that all VA facilities comply with this policy.

VA Comment: Concur. CBOPC will:

- Review current national procedure guides and, if needed, clarify communication requirements to ensure that guidelines emphasizing the importance of properly verifying claims have been sent to the correct facility. Anticipated completion date: March 31, 2014.

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- Create an article and publish it in the CBOPC bi-weekly publication titled *The Bulletin* reminding staff of national operating guides covering the procedure guides and trainings available for current processing expectations for routing claims. Anticipated completion date: March 31, 2014.
- Announce on the NNPO national call in February 2014 and the next quarterly VISN BIM call to clarify policies and guidance for processing Millennium Act claims. Anticipated completion date: March 31, 2014.
- Review and update the FA checklist to ensure VA facilities’ compliance with the national guidelines to properly verify claims have been sent to the correct facility. Anticipated completion date: March 31, 2014.

Recommendation 4: Revise VA policy for processing Millennium Act claims to require that VA fee basis staff who process the claims use the VSSC Find User search to make determinations about veterans’ enrollment and use of VA services.

VA Comment: Concur. CBOPC will review current national procedure guides and update them, if necessary, to ensure the tool is listed as a best practice. Anticipated completion date: June 30, 2014.

Recommendation 5: Establish a VA policy regarding processing Millennium Act claims to require VA facilities to assist the veteran in determining whether a claim is eligible for coverage by auto insurance or another third party before denying the claim. Also, ensure that the standard letters sent to veterans whose claims are denied because of third party liability, in this case auto insurance coverage, more clearly communicate that the denial could be overturned if the veteran can prove that auto insurance did not fully cover the claim.

VA Comment: Concur. VAMCs adhere to Veterans Claims Assistance Act notice requirements which address procedures on claim eligibility. However, to strengthen adherence to this policy, CBOPC will:

- Assess current processes to determine best practices. For example, one option would be to return claims with potential auto insurance coverage for additional information as opposed to denying the claim. Anticipated completion date: June 30, 2014.

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- Assess standardized letters and current system capabilities for enhancement to include additional clarification of auto insurance as opposed to other third party liability processes and requirements. Anticipated completion date: June 30, 2014.
- Review current verbiage in national procedure guides to provide further clarification and detailed instructions. Anticipated completion date: June 30, 2014.

Recommendation 6: To better ensure that veterans are notified of Millennium Act emergency care claim denials, require fee basis supervisors at each VA facility to develop mechanisms for verifying that veteran denial letters are printed and mailed.

VA Comment: Concur. This is already a requirement of the field; however, to strengthen adherence to the policy, CBOPC will:

- Assess feasibility to enhance FBCS to allow a notation be added in FBCS to document that Preliminary Fee Remittance Advice Reports and Veteran letters are printed, and the corresponding dates are stored in the claim history. Anticipated completion date: June 30, 2014.
- Develop and publish an article in the CBOPC bi-weekly publication titled *The Bulletin*, reiterating the need to queue and mail letters daily to both Veterans and vendors. Anticipated completion date: March 31, 2014.
- Announce on the quarterly BIM VISN call the need for VAMCs/VISNs to develop local tracking mechanisms to ensure and verify Veteran denial letters are printed and mailed out. Anticipated completion date: March 31, 2014.
- Review and update the FA checklist to ensure VA facilities are complying with national guidelines for sending Veteran and vendor denial letters. Anticipated completion date: March 31, 2014.

To improve oversight of Millennium Act claims processing by increasing its focus on determining whether claims are inappropriately denied and ensuring that deficiencies are corrected:

Recommendation 7: Revise the scope of field assistance visits to include an assessment of whether fee basis staff are making appropriate decisions about

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whether Millennium Act claims meet administrative and clinical criteria for payment.

VA Comment: Concur. NNPO FA staff will review the current list of FA interview questions and incorporate clarification questions for administrative and clinical criteria for payment. Anticipated completion date: March 31, 2014.

Recommendation 8: Require VA facilities to systematically audit the appropriateness of Millennium Act claim approvals and denials by taking actions, such as revising VA Central Office’s internal controls procedure guide for fee basis managers or by establishing performance measures related to the appropriateness of claim approval or denial decisions for fee basis staff.

VA Comment: Concur. CBOPC deployed a Virtual Audit Team in December 2013. This team performs audits on only paid claims for the annual Improper Payment Elimination and Recovery Act audit as well as quarterly proper payment audits and specialty audits on focused areas to include Millennium Act claims. Audit findings and corrective action plans are established and tracked in a Quality Corrective Action Plan database. Results are evaluated to determine improvement.

CBOPC will review the Internal Controls Procedure Guide as it relates to Millennium Act denials and update the Guide, if necessary. Anticipated completion date: June 30, 2014.

Recommendation 9: Require VA facilities to correct fee basis claims processing deficiencies that are identified through field assistance visits or virtual audits, once they are implemented, and establish a process for validating facilities’ self-reported actions taken to address deficiencies.

VA Comment: Concur. CBOPC will establish procedures for identifying and reporting non-compliant sites to CBOPC/VHA senior leadership for further action, as needed. Anticipated completion date: June 30, 2014.

To improve VA’s ability to identify systemwide patterns in denials, areas of noncompliance in VA facilities’ processing of Millennium Act claims, and areas where communications for veterans and non-VA providers could be improved:

Recommendation 10: Establish a standard set of Millennium Act denial reasons in FBCS that are specific and aligned with the Millennium Act administrative and clinical criteria, and ensure they are consistently applied across VA facilities.

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VA Comment: Concur. VHA previously submitted a request to the VA Office of Information and Technology (OIT) for FBCS enhancement; however, OIT did not fund the enhancement. To work around the potential funding issues, CBOPC will:

- Review and enhance, if necessary, the national procedure guides. Anticipated completion date: June 30, 2014.
- Assess the implications of lock down of denial reasons in FBCS which would prevent users from being able to make changes locally. Anticipated completion date: June 30, 2014.
- Assess an alternate option of FBCS logic if the Millennium Act only displays limited denial reason options. Anticipated completion date: June 30, 2014.

Recommendation 11: Establish a regular reporting mechanism through which VA facilities would provide to VA Central Office data related to the appropriateness of decisions to approve or deny Millennium Act claims.

VA Comment: Concur. CBOPC will assess the ability and feasibility of tracking and reporting stations’ claims denial and approval reasons. Anticipated completion date: June 30, 2014.

Recommendation 12: To improve VA’s ability to address its strategic plan objective of educating and empowering veterans, take steps to better understand gaps in veterans’ knowledge regarding eligibility for Millennium Act emergency care, such as by conducting veteran surveys of health care benefits knowledge, and using information from those surveys to more effectively tailor the agency’s education efforts regarding the Millennium Act benefit. In conducting these surveys, consideration should be given to including a sample of veterans who have had denied Millennium Act claims in order to provide their views and specific details of their experiences.

VA Comment: Concur. CBOPC will:

- Partner with the Health Eligibility Center to determine survey options. Anticipated completion date: April 30, 2014.
- Explore attending Veterans Service Organization conferences/Town Hall Meetings to promote Veteran education. Anticipated completion date: April 30, 2014.

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- Review current information on the public Web site to ensure information is up to date and, if necessary, update the Web site. Anticipated completion date: April 30, 2014.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; Stella Chiang; Daniel K. Lee; Alexis C. MacDonald; Elizabeth T. Morrison; Lisa Motley; and Jennifer Whitworth were major contributors to this report.

Related GAO Products

VA Health Care: Additional Steps Needed to Strengthen Beneficiary Travel Program Management and Oversight. [GAO-13-632](#). Washington, D.C.: July 15, 2013.

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

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