THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

JUN 2 8 2019

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File No. DI-17-3205

Dear Mr. Kerner:

I am responding to your April 9, 2018, letter regarding allegations made by Whistleblower the whistleblower, who alleged that employees at the Veterans Integrated Service Network 6 in Durham, North Carolina, engaged in actions that may constitute a violation of law, rule or regulation; gross mismanagement; and a gross waste of funds.

The Executive in Charge, Office of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a Department of Veterans Affairs team to conduct an investigation. We investigated this matter from June 4–7, 2018, and submitted a draft report to the Office of Special Counsel (OSC) on April 4, 2019. VA addressed additional concerns raised by OSC following its review of the draft report and modified several report recommendations to reflect our recent discussions with your office. Regarding the whistleblower's five allegations, we have substantiated one allegation but do not substantiate the remaining four allegations. We make six recommendations to the Veterans Health Administration on this matter.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-17-3205

Department of Veterans Affairs (VA)
Veterans Integrated Service Network (VISN) 6
Durham, North Carolina

Report Date: June 25, 2019

TRIM 2018-D-3373

Executive Summary

The Executive in Charge, Office of the Under Secretary for Health, directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Veterans Integrated Service Network (VISN) 6 in Durham, North Carolina. Whistleblower (the whistleblower), who consented to the release of his name, alleged that employees are engaging in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a gross waste of funds by VA. The VA team conducted a site visit on June 4–7, 2018.

Specific Allegations of the Whistleblower

1. *VISN 6 has failed to timely reimburse health care providers under the Veterans Choice Program (VCP) [and the Non-VA Medical Care Program, the predecessor program][1], which resulted in those providers terminating services for Veterans and referring hundreds of Veterans to collection agencies for non-payment.*

2. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately January 2014.*

3. *The VTP has not required audits of medical centers' Beneficiary Travel (BT) Program payments, instead auditing only the sites that volunteer to participate, resulting in grossly inaccurate reports of improper payments to Congress.*

4. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately November 2016.*

5. *VA failed to properly measure and report to Congress improper payments for Special Mode Transportation (SMT) under the VTP BT Program.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, we make the following conclusions and recommendations, which will be followed through to completion through an action plan:

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[1] Traditional Non-VA Medical Care is not a predecessor program to the Veterans Choice Program (VCP). Traditional Non-VA Care still exists and is an important way in which Veterans receive Care in the Community (CITC). CITC has expanded over the years to improve care delivery and accessibility to Veterans.

Conclusions for Allegations 1 and 2

- We **substantiate** that VISN 6 failed to timely reimburse community health care providers, which resulted in some of those providers terminating services for Veterans and referring Veterans to collection agencies for nonpayment. Reiterating that VISN 6 was only responsible to reimburse providers that had agreements directly with, the Veterans Health Administration (VHA), and not those who contracted with Third Party Administrators.

- We **do not substantiate** that leadership failed to take appropriate action to address the above issue when put on notice by Whistleblower in approximately January 2014.

- When the *Prompt Payment Act* is applicable, VHA often fails to pay within the required timeframe and the claims payment process currently in place does not support timely payments in VISN 6 or any other VISN throughout VHA.

- Staff members at the Office of Community Care Claims Adjudication and Reimbursement (CAR) Payment Center located in Salem, Virginia, receive claims at a rate that outpaces their capacity to process the claims efficiently.

- On average, only 51 percent of the claims received in CAR from Fiscal Year (FY) 2014 through 2nd quarter FY 2018 are clean claims.

- VISN 6 Leadership was actively engaged in addressing the claims backlog.

Recommendations to VHA

1. Employ industry standard automated solutions for providers to submit claims for care delivered and for VA to pay claims for Non-VA Care to improve payment timeliness and accuracy.

2. Conduct a nationwide campaign to engage and educate current and potential community providers and their billing staff on how to submit claims to VA. Initiate this plan immediately and provide evidence of actions taken.

3. Develop a strategy to resolve unpaid claims and clear the unpaid claims backlog. Initiate this plan immediately and provide evidence of actions taken.

4. Re-evaluate the current claims payment process, make necessary adjustments, and work to further automate the process to include an immediate feedback loop to providers if they submit an unclean claim.

5. Ensure each payment center has adequate staff to manage the volume of claims they are expected to process.

Conclusions for Allegations 3, 4, and 5

- We **do not substantiate** that, "the VTP has not required audits of VA medical centers' (VAMC) Beneficiary Travel Program (BTP) payments, instead auditing only the sites that volunteer to participate, resulting in grossly inaccurate reports of improper payments to Congress (as required by the Improper Payments Elimination and Recovery Act of 2010)."

- There is no law, rule, or regulation that requires the Veterans Transportation Service (VTP) to audit the BTPs. (However, both internal and external entities audit our BTPs annually.

- We **do not substantiate** that VA leadership failed to take appropriate action to address the above issue when put on notice by Whistleblower in approximately November 2016.

- VA leaders have devised action plans annually in response to the Office of Inspector General's (OIG) annual evaluations, and, although there have been some improvements, the financial software program in place does not meet government compliance and is vulnerable to errors.

- We **do not substantiate** that VA failed to properly measure and report to Congress improper payments for SMT under the VTP BTP because there is no specific data related to SMT. VA reports SMT improper payments in its Annual Financial Report (AFR) under the BTP.

- VA reports SMT improper payments in its AFR under the BTP; as a component of the BTP, there should be no expectation for VA to report SMT improper payments separately.

- In the absence of proper management controls, VHA will continue to waste funds by improperly making BT payments that result in a monetary loss.

Recommendation to VHA

6. Address the open OIG recommendations, and, in the absence of a reliable and current financial management system, implement efforts to ensure the existing system supports an environment where improper reimbursements are prevented, or detected and corrected in a timely manner. If it is not possible to improve the existing system, explore options for a replacement.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that VISN 6 may have violated law, rule, or regulation, engaged in gross mismanagement; and a gross waste of funds by the VA. In particular, VHA

National Center for Ethics in Health Care has provided a health care ethics review. We did not find violations of VA and VHA policies; however, we found that a gross waste of funds existed within VHA related to improper BT payments.

Table of Contents

Executive Summary ii

I. Introduction 1

II. Facility Profile 1

III. Specific Allegations of the Whistleblower 1

IV. Conduct of Investigation 2

V. Background, Findings, Conclusions, and Recommendations 3

Allegations 1 and 2 3

Background 3

Veteran Enrollment 3

Community Care 3

Provider Billing and Reimbursement Process 5

Patient Accounting 6

Findings 6

Barriers to Timely Reimbursement 7

Conclusions for Allegations 1 and 2 10

Recommendations to VHA 11

Allegations 3, 4, and 5 11

Background 11

Beneficiary Travel 11

Improper Payments 12

Travel Reimbursement 13

Findings 13

Audits 13

Leadership Actions 15

Reports to Congress of Inaccurate Payments 15

Conclusions for Allegations 3, 4, and 5 16

Recommendation to VHA 17

VI. Summary Statement 17

Attachment A 18

Attachment B 19

I. Introduction

The Executive in Charge, Office of the Under Secretary for Health, directed that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning Veterans Integrated Service Network (VISN) 6 in Durham, North Carolina. Whistleblower (the whistleblower), who consented to the release of his name, alleged that employees are engaging in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a gross waste of funds by VA. The VA team conducted a site visit to Asheville, North Carolina, on June 4–7, 2018.

II. Facility Profile

VISN 6 is one of 21 VISNs of the Veterans Health Administration (VHA) and is comprised of 7 VA medical centers (VAMC) and 33 community-based outpatient clinics (CBOC). Over 18,500 clinical and support staff members and more than 4,000 volunteers serve over 318,000 Veterans annually within service areas of Richmond, Hampton, and Salem, Virginia, and Fayetteville, Durham, Salisbury, and Asheville, North Carolina. In Fiscal Year (FY) 2017, VISN 6 provided care for 390,808 Veterans in 6.2 million outpatient encounters and 28,626 hospital admissions.

III. Specific Allegations of the Whistleblower

1. *VISN 6 has failed to timely reimburse health care providers under the Veterans Choice Program (VCP) [and the Non-VA Medical Care Program, the predecessor program],* [2] *which resulted in those providers terminating services for Veterans and referring hundreds of Veterans to collection agencies for non-payment.*

2. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately January 2014.*

3. *The VTP has not required audits of medical centers' Beneficiary Travel (BT) Program payments, instead auditing only the sites that volunteer to participate, resulting in grossly inaccurate reports of improper payments to Congress.*

4. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately November 2016.*

5. *VA failed to properly measure and report to Congress improper payments for Special Mode Transportation under the VTP BT Program.*

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[2] Traditional Non-VA Medical Care is not a predecessor program to the VCP. Traditional Non-VA Care still exists and is an important way in which Veterans receive Care in the Community (CITC). CITC has expanded over the years to improve care delivery and accessibility to Veterans.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of the Medical Inspector and a Clinical Program Manager from OMI, and an Investigator from the VA Office of Accountability and Whistleblower Protection. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A, and held entrance and exit briefings with VISN 6 and medical center leadership, followed by face-to-face and telephone interviews at Asheville, where the whistleblower and those mentioned in the referral letter were or are employed.

We interviewed the whistleblower via teleconference on May 7, 2018. We interviewed the following current and former VISN 6 employees:

- Former Asheville VAMC Medical Center Director (MCD), June 2010–July 2017
- Chief of Staff (CoS), Asheville
- Associate Director for Patient Care Services/Chief Nurse Executive, Asheville
- National Program Director, Veteran Transportation Service
- Veteran Transportation Program Deputy Director
- Chief, Health Administration Service (HAS), Asheville
- Assistant Chief, HAS, Philadelphia
- Supervisory Auditor, VHA Financial Assistance Office
- Supervisory Medical Administration Specialist, HAS, Asheville
- Supervisory Medical Support Assistant, HAS, Asheville
- Supervisor, Clinics, HAS, Asheville
- Medical Administration Officer (AO), HAS, Asheville
- CITC Nurse Navigator, Asheville
- Group Practice Manager (GPM)/Interim Chief, CITC, Asheville
- Program Analyst, GPM, Asheville
- Program Analyst, VHA Community Care, Denver
- Program Specialist, Member Services, Michigan
- VISN 6 VA Community Care Manager, Claims Adjudication & Reimbursement (CAR)
- Community Care Supervisor
- AO, Logistics, Asheville
- AO, Social Work, Asheville
- Patient Advocate, Asheville
- Director of Mid-Atlantic CAR
- Former Associate Director, Asheville VAMC

V. Background, Findings, Conclusions, and Recommendations

Allegations 1 and 2

1. *VISN 6 has failed to timely reimburse health care providers under the VCP [and the Non-VA Medical Care Program, the predecessor program], which resulted in those providers terminating services for Veterans and referring hundreds of Veterans to collection agencies for non-payment.*

2. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately January 2014.*

Background

Veteran Enrollment

Per section 1705(c) of Title 38, United States Code (U.S.C.), Veterans generally must enroll to receive VA health care. Enrollment helps to ensure that comprehensive health care services will be available for Veterans when needed. Enrolled Veterans are eligible to receive health care as provided in the Medical Benefits Package under 38 C.F.R. § 17.38, which includes preventive, primary and specialty care, diagnostic, inpatient and outpatient care services. During enrollment, each Veteran is assigned to a priority group in a range from 1–8, with 1 being the highest priority for enrollment (Attachment B). VA uses priority groups to balance demand for VA health care with VA resources.[3] Veterans in certain subcategories of priority group 8 are not currently eligible for enrollment.

While many enrolled Veterans qualify for certain VA health care without copayments based on a VA compensable service-connected condition or other special eligibilities, certain Veterans must complete a financial assessment at the time of enrollment to determine whether they qualify for VA health care services without copayments. Those whose income exceeds VA income limits, as well as those who choose not to complete the financial assessment at the time of enrollment, must agree to pay required copays to become eligible for VA health care services.

Community Care

Veterans are using community care more than ever before. In FY 2016, more than 25.5 million appointments were scheduled across our multiple CITC programs. Each program has different eligibility standards and processes, which unfortunately has created confusion for Veterans and their families, community providers, and our staff. Traditional Non-VA Medical Care is not a predecessor program to the VCP. Traditional Non-VA Care still exists and is an important way in which Veterans receive CITC. CITC has expanded over the years to improve care delivery and accessibility to Veterans.

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[3] VHA Handbook 1601A.03, *Enrollment Determinations*, September 25, 2015.

VA purchases care in the community by entering into Choice Provider Agreements or contracts, either directly with providers or with Third Party Administrators (TPA) who manage a network of community providers.

For this report, we will only cover VA's responsibilities with respect to community providers with whom VA has a direct relationship. Although we also discuss the processes applicable when VHA refers Veterans to TPAs, because we believe the multiple processes cause some confusion, the findings and conclusions of the report are limited to VA payments made directly to providers.

Traditional Non-VA Care

Historically, VA purchased most community care under the authority in 38 U.S.C. 1703 (formerly known as Fee Basis Care, Purchased Care, or Non-VA Medical Care), which authorizes VA to purchase care from community providers for eligible Veterans when treatment or services are not feasibly available or geographically accessible at the nearest VA medical facility. VA refers Veterans as needed, based on clinical needs, and issues an individual authorization to the community provider with approved care instructions. For care authorized using an individual authorization, VA pays providers directly.

Patient-Centered Community Care

On September 19, 2013, VA announced new contracts known as Patient-Centered Community Care (PC3), which gave VAMCs an additional option to purchase non-VA medical care for Veterans through a contracted network of medical providers when the VAMC cannot readily provide the needed care due to geographic inaccessibility or limited capacity. Under PC3, unlike traditional VA Community Care, VA uses regional contracts with TPAs who allow VA access to a network of local community providers. VA awarded two contracts, one to HealthNet Federal Services (HealthNet) and the other to TriWest Healthcare Alliance Corporation (TriWest).[4] The providers that render care as part of these networks enter into agreements with HealthNet and Triwest and not with VA. VA orders services from TPAs and is responsible for paying them, but the payment to the provider is made by TPAs and that payment is only governed by whatever agreement exists between them and TPA.

Veterans Choice Program

On August 7, 2014, President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). Part of this law included the establishment of VCP. To provide care under VCP, VA modified the existing PC3 contracts. For VCP, TPAs are responsible for educating Veterans on how to use their services, managing the Veterans Choice Card distribution, Call Center, provider management, appointment management, reporting, and billing. For a period of time before the law was amended,

[4] Department of Veterans Affairs News Release, September 19, 2013.

they also were responsible for coordinating Veterans' health insurance information with their providers and providing VA with an Explanation of Benefits for payment. VA reimburses TPA and has no financial obligation to their contracted providers.

In instances where it is impracticable to acquire the necessary services through contracts or sharing agreements, VA is also authorized to enter into agreements, known within VA as Choice Provider Agreements, directly with individual providers.[5] In those circumstances, VA pays the providers directly.

All VA CITC is subject to specific eligibility criteria, depending on what statutory authority is being relied upon for the care.

Provider Billing and Reimbursement Process

VHA's provider billing and reimbursement process is distinctively different from TPAs. TPA's process is mentioned here to emphasize the separate and independent processes that providers encounter, potentially impacting the provider's understanding and compliance with the instructions detailed in the authorizations.

VHA Process:

Providers receive an authorization prior to rendering care. When VHA refers care to providers they send VA authorization forms 10-7078 or 10-7079, for outpatient or inpatient care respectively.[6] The authorization specifies what care is authorized, associated diagnosis codes, the validity period, frequency of care being rendered, instructions for seeking secondary authorizations and requesting additional services, and in some instances, VHA's payment methodology. The associated Provider Toolkit includes instructions and requirements for submitting claims for payment. Some examples of information required on the claims for each service include: 1) Veteran's full name and address; National Provider Identifier (NPI) and tax identification number of the provider; 2) dates of service; 3) itemized charges; and 4) an appropriate diagnostic code or codes. When these claims are received, they go through a scrubbing process and VA's Program and Quality Integrity Tools for accuracy. This process ensures all required information is on the claim and the claim is processed according to VHA guidelines. VHA CAR staff reject claims back to the provider if billing guidelines are not followed, for example if the process identifies errors or missing information.[7] This often results in delayed payments.

TPA Process:

Prior to April 2017, providers were required to bill other health insurers prior to billing TPA (or VA for care authorized under a Choice Provider Agreement) for care for

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[5] https://vaww.va.gov/choice/. Accessed June 15, 2018.

[6] VA Form 10-7079, *Request for Outpatient Services*, and VA Form 10-1078, *Authorization and Invoice for Medical and Hospital Services.*

[7] https://www.va.gov/COMMUNITYCARE/providers/info_claimFiling.asp.

non-service-connected conditions authorized under VCP. Currently, after TPA accepts a referral from VHA and schedules care with the provider, the provider, after rendering care, sends a claim to TPA. TPA adjudicates the claim for payment and pays the provider. TPA then submits an electronic claim to VA for reimbursement.

As mentioned, if a provider joins TPAs' PC3 or Choice network, the relationship between TPA and the provider does not involve VA in anyway. VA is not the party responsible for reimbursing the providers' claims nor does VA control how quickly TPA pays the provider.

Patient Accounting

VHA must perform revenue utilization review activities under certain circumstances. In 2008, 38 U.S.C. 1729B authorized VHA to implement Consolidated Patient Account Centers (CPAC). In 2009, the Mid-Atlantic CPAC (MACPAC), located in Asheville, North Carolina, became the first fully functional center and currently is one of seven regional CPACs; it is responsible for billing the non-VA care claims processed by the CAR office for Asheville. Both of these offices are located in Salem, Virginia, on the campus of the Salem VAMC.

Findings

VHA's goal is to process all claims, submitted directly from community providers, in the most timely and efficient manner possible. Authorized claims are considered aged when they are not processed (rejected, denied, accepted, and paid) within 30 days of receipt; or 45 days of receipt for unauthorized or Millennium Bill claims. The problem of aged claims has persistently plagued VHA, and, despite many process improvement efforts over the years, barriers to meeting that goal remain a constant challenge. In addition to the sheer volume of claims submitted (see Table 1), VHA consistently receives incomplete or inaccurate claims from community providers. VHA must return these claims, i.e., reject them, for correction or completion, imposing further delays. Despite widespread communication and education strategies, VHA providers, TPAs, Veterans, and staff find it difficult to understand the complexities of health care billing and payment.

We reviewed email traffic between the staff at Asheville and CAR, and letters of complaint from providers dating back to June 2013. The documents detail the frustration of CITC providers over their unpaid VA claims and the concerted effort of Asheville and CAR staff to address those complaints. One email listed 11 community providers refusing to see Veterans because of nonexistent or delayed VHA payments. As VACAA has only been in effect since August 2014, earlier complaints are an indication that the problem is broader than VCP and includes other community care programs.

Although no one provided letters from Veterans complaining that they had been referred to bill collectors or provided us with any tools that track the number of Veterans sent to

collections, several staff members told us that the leadership throughout VISN 6 assigned them to investigate such complaints.

Barriers to Timely Reimbursement

The increasing volume of claims submitted, errors found within those claims submitted, and the meticulous process in place to pay the claims all contribute to delayed reimbursement.

Claims Volume

We reviewed the claims status for VISN 6 CITC vendors from FY 2014 through the end of FY 2018, which showed providers, over that period, submitted 5,280,603 claims to the CAR. Table 1 shows claims processed by CAR nearly doubled from FY 2014 to FY 2015 and that volume was sustained through FY 2017 with an increase of over 300,000 claims in FY 2018. Six Full-Time Employee Equivalents processed an average of nearly 5,000 claims per day. The status also shows that on average, only 51 percent of claims submitted are considered clean and accepted as valid for payment.[8]

CAR Community Care Claims Status – Comparison Between FYs

	CLAIMS PROCESSED				CLAIMS NOT PROCESSED		
FY	Total Claims	Accepted	Rejected	Denied	Suspended	Not Processed	In Payment
2014	627,422	283,546 (45%)	266,210 (42%)	77,666 (12%)	1	12	11
2015	1,147,927	593,465 (52%)	412,332 (36%)	142,130 (12%)	6	62	13
2016	1,094,760	558,478 (51%)	451,765 (41%)	84,517 (8%)	17	53	16
2017	1,016,829	512,130 (50%)	465,907 (46%)	38,792 (4%)	47	207	64
2018	1,393,665	800,288 (57%)	560,855 (46%)	32,522 (2%)	4287	33,740	3,038

Table 1

Claims Submission Errors

Claims submission errors are another barrier to remitting payment in a timely manner. The claims process for PC3/Choice contracts differ substantially from Choice Provider Agreements and individual authorizations. Providers must closely follow the instructions in the authorization to avoid submission errors because it is possible for them to render care to a Veteran under different authorities using different purchasing mechanisms and with different billing processes.

For example, when care is authorized under the PC3/Choice contract, the VISN 6 TPA, HealthNet, sends the provider a package that includes the consultation and the relevant medical background, generated specifically for that Veteran, and billing instructions. When the provider renders the care, he or she submits the claim to TPA for payment, and TPA pays the provider and then invoices VA. HealthNet has found that providers

[8] A clean claim is one that has all information required for processing in a timely manner; it has no defect, impropriety, or special circumstance.

often do not read the instructions and subsequently do not bill correctly. For incorrect bills, HealthNet is unable to make payments while adjudicating claims with the providers.

Alternatively, VA may authorize care directly with an individual provider using individual authorizations or Choice Provider Agreements. In both cases, authorizations for care include detailed instructions for how and where to submit claims for the care rendered under that specific authorization. The following scenario occurs and leads to confusion surrounding claims submission errors:

> Veteran A and Veteran B present to the provider's office, each with authorizations for care. TPA-referred Veteran A and his authorization instructs the provider to submit claims to TPA. Asheville referred Veteran B under a Choice provider agreement, and the authorization instructs the provider to submit claims to the CAR. Prior to April 2017, an additional scenario could have existed. If TPA or Asheville referred Veteran C to a provider for care of a non-service connected condition, the provider had to bill the Veteran's other health insurance, if applicable, prior to billing TPA or CAR.

Former CAR staff members told us that the VHA Office of Community Care (OCC) assigned several additional staff members in 2016, who were responsible for contacting providers to expedite payments. They learned the providers had been submitting claims to the wrong address and coding the claims improperly; some of the claims never reached CAR for processing.

Claims Processing

Depending on how the care is authorized, either TPA or CAR processes community provider claims. As mentioned previously, VHA does not reimburse providers who have agreements with TPAs. However, despite the billing instructions contained in the authorizations to providers, occasionally providers, in error, submit claims intended for TPA to CAR and conversely, submitted claims intended for CAR to TPA.

When TPA refers a Veteran to a community provider, the provider submits claims for payment back to TPA. TPA is responsible for making payment in accordance with whatever agreement exists between the provider and TPA. VA is not a party to that agreement and has no responsibility to make payment in these situations.

However, if VHA refers the Veteran to a community provider through a Choice Provider Agreement or traditional CITC authorization, the provider submits claims for reimbursement to CAR. When the provider's claim reaches CAR, staff members there are responsible for processing it and making payment to the provider. When the claims are clean, there are no authorization issues, and funding is in place, VHA remits payment within the 30 days as required by the *Prompt Payment Act* (PPA), if

applicable.[9] Unfortunately, as noted in Table 1, 49 percent of claims are not clean and therefore are at risk of not being paid timely and not meeting the standards of the PPA; if applicable. The CAR staff told us they have the greatest burden in claims processing because they must ensure the accuracy of each claim before paying it. This meticulous process causes a bottleneck at the CAR, delays payments, and contributes to providers holding the Veterans responsible for payment. After the CAR completes their processes, through the finalization process in the FBCS payment module, claims are forwarded to the Financial Services Center in Austin, Texas, to issue payment via the Department of Treasury (Treasury). Once Treasury pays the claim, Asheville then completes the medical coding for the claim and forwards it to the MACPAC, which then, if indicated, bills Veterans and private insurance companies for their portions of the payment for care rendered to Veterans.

Leadership Actions

In 2014, when VISN 6 learned that CAR was not processing claims in a timely manner and Veterans were complaining about collection notices, they formed a team of staff members from Asheville and CAR, headed by OCC, to collaborate with providers to determine the source of the problem and map out a strategy to address it. The VISN assigned additional staff to CAR to assist with claims processing. Asheville staff worked with providers to get detailed, accurate accountings of their outstanding claims, and the team worked directly with Veterans while attempting to settle the claims. One interviewee told us that "This Medical Center was very engaged, aware, and worked closely with the VISN trying to do damage control." Another said the former Associate Director at Asheville and the OCC were fully engaged in efforts to process claims, stating "it's not that nothing happened, they were chipping away at the pile." When the former Associate Director became aware of the problem, she required biweekly, then monthly, teleconferences with her and the OCC to address the outstanding payments.

In addition to the local efforts, on October 30, 2015, VA provided Congress with a *Plan to Consolidate Community Care Programs* consistent with the *VA Budget and Choice Improvement Act* signed into law in July of the same year, and recommendations from the *Independent Assessment Report.*[10] VA stated in the plan that it recognized it was not meeting the standards of the PPA, where applicable, and identified a root cause of the low PPA compliance was that claims payment is a manual process, creating a significant backlog. VA has not automated the process further but expects to reach compliance goals by June 2019.

We learned that providers refer Veterans to collections for unpaid debt for many reasons. As the CAR staff investigated providers' complaints for delayed payments,

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[9] The PPA applies to contracts. This includes VA's payments to TPAs, payments to providers under individual authorizations (traditional non-VA care/fee basis), and payments under other 1703 contracts and 8153 contracts. PPA does not apply to Choice Provider Agreements (because they are exempt from laws governing Federal contracts) or TPAs' payments to providers (because VA is not a party to the agreement).

[10] Title IV of the *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015* (VA Budget and Choice Improvement Act) Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care, October 30, 2015.

they found in some instances that the providers had not followed the instructions in the authorization and billed the Veteran directly instead of VHA. When the Veterans rightfully refused to make the payment, the provider referred them to collections. In other instances, CAR rejected the provider's claim because it had been submitted in error and instead of the providers resubmitting a corrected claim, they billed Veterans and subsequently referred them to collections when they did not remit payment.

In 2015, OCC established the Community Care Contact Center (C4). In February 2016, OCC created a unit within C4, the Community Care Call Center, to assist Veterans with adverse credit and collections issues resulting from nonpayment of Community Care claims. The staff at the call center is also trained to work with providers to expunge adverse credit reporting on Veterans resulting from delayed payments to providers. The call center contacts the provider to request that they place the Veteran's account in a hold status; collaborates with partner groups to see whether the provider's claim can be paid; and then informs the Veteran of the outcome. We reviewed the earliest adverse credit data maintained by C4 for VISN 6 which showed they assisted 264 Veterans with adverse credit between September – December 2016, and in 2017 the number of Veterans they assisted was 2,538.

Conclusions for Allegations 1 and 2

- We **substantiate** that VISN 6 failed to timely reimburse community health care providers, which resulted in some of those providers terminating services for Veterans and referring Veterans to collection agencies for nonpayment. Reiterating that VISN 6 was only responsible to reimburse providers that had agreements directly with VHA, and not those who contracted with TPAs.

- We **do not substantiate** that leadership failed to take appropriate action to address the above issue when put on notice by Whistleblower in approximately January 2014.

- When the *Prompt Payment Act* is applicable, VHA often fails to pay within the required timeframe, and the claims payment process currently in place does not support timely payments in VISN 6 or any other VISN throughout VHA.

- Staff members at the CAR Payment Center located in Salem, Virginia, receive claims at a rate that outpaces their capacity to process the claims efficiently.

- On average, only 51 percent of the claims received in CAR from FY 2014 through 2nd quarter FY 2018 are clean claims.

- VISN 6 Leadership was actively engaged in addressing the claims backlog.

Recommendations to VHA

1. Employ industry standard automated solutions for providers to submit claims for care delivered, and for VA to pay claims for Non-VA Care to improve payment timeliness and accuracy.

2. Conduct a nationwide campaign to engage and educate current and potential community providers and their billing staff on how to submit claims to VA. Initiate this plan immediately and provide evidence of actions taken.

3. Develop a strategy to resolve unpaid claims and clear the unpaid claims backlog. Initiate this plan immediately and provide evidence of actions taken.

4. Re-evaluate the current claims payment process, make necessary adjustments, and work to further automate the process to include an immediate feedback loop to providers if they submit an unclean claim.

5. Ensure each payment center has adequate staff to manage the volume of claims they are expected to process.

Allegations 3, 4, and 5

3. *The VTP has not required audits of Medical Centers' Beneficiary Travel (BT) Program payments, instead auditing only the sites that volunteer to participate, resulting in grossly inaccurate reports of improper payments to Congress (as required by the Improper Payments Elimination and Recovery Act of 2010).*

4. *VA leadership failed to take appropriate action to address the above issue when put on notice by* Whistleblower *in approximately November 2016.*

5. *VA failed to properly measure and report to Congress improper payments for Special Mode Transportation under the VTP BT Program.*

Background

Beneficiary Travel

VTP comprises Beneficiary Travel Program (BTP) and two other business lines. BTP establishes guidance and processes governing payments and allowances to eligible Veterans for costs relating to their travel for VHA or VHA-authorized care. They primarily assist medical centers with regulatory interpretation, training, education, and other consultative services.

The purpose of BTP is to help alleviate the costs of travel to medical and other appointments for eligible Veterans. Under 38 U.S.C. § 111, VA has the authority to pay the actual necessary expense of travel, or in lieu thereof an allowance based upon

mileage (at a rate of 41.5 cents per mile), for eligible individuals to or from a VA facility or other place in connection with vocational rehabilitation; counseling required by VA pursuant to chapters 34 or 35 of title 38, U.S.C.; or for the purpose of examination, treatment, or care. Under BTP, VHA provides payment for travel performed by a special mode of transportation (SMT) when certain criteria are met. SMT means ambulances, ambulettes, air ambulances, wheelchair vans, or other modes of transportation that are specially designed to transport disabled individuals.[11]

Improper Payments

The Office of Management and Budget (OMB) Circular A-123, Appendix C, describes improper payments as "any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements."[12] This includes "overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for an incorrect amount, and duplicate payments)" and "any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments authorized by law)."[13]

Congress enacted the Improper Payments Information Act of 2002 (IPIA) "[i]n an effort to reduce and ultimately eliminate billions of dollars in improper payments made by federal agencies each fiscal year."[14] The law "established an initial framework for identifying, measuring, preventing, and reporting on improper payments at each agency."[15]

In 2010, Congress passed the *Improper Payments Elimination and Recovery Act* of 2010 (IPERA), which "retained the core provisions of the IPIA while requiring improvements in agency improper payment estimation methodologies and improper payment reduction plans."[16] The 2010 IPERA was amended by the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), and requires agencies to "improve the quality of oversight for high-dollar and high-risk programs, and it mandates that agencies share data regarding recipient eligibility and payment amounts."[17] Where the risk of improper payments is assessed as potentially significant, agencies are required to estimate the annual amount of improper payments and report the estimates in their annual report (Performance and Accountability Report (PAR) or Annual Financial Report (AFR)) to OMB, along with plans and targets to reduce improper payments. OMB Circular A-123, Appendix C, specifies that each agency's Inspector

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[11] VHA Handbook 1601B.05, *Beneficiary Travel*, July 21, 2010.
[12] OMB Circular A-123, Appendix C, *Requirements for Payment Integrity and Improvement.* Revised, June 26, 2018 *available at* https://www.whitehouse.gov/wp-content/uploads/2018/06/M-18-20.pdf.
[13] Ibid.
[14] Congressional Research Service, *Improper Payments and Recovery Audits: Legislation, Implementation, and Analysis*, Garrett Hatch (October 18, 2013), available at https://fas.org/sgp/crs/misc/R42878.pdf.
[15] Ibid.
[16] Ibid.
[17] Ibid.

General annually review improper payment reporting in the agency's PAR or AFR, and issue a report of the agency's compliance with IPERA.

Travel Reimbursement

The Application Division of Financial Claims Management Office is the steward of the Central Fee (Fee) system. The Fee system is a central repository for financial and medical data collected during Fee Basis claims processing and from Veterans Health Information Systems and Technology Architecture (VistA) Fee facility stations. VistA Fee interfaces with the Financial Management System (FMS) and the Purchase Card system.[18] Fee processes beneficiary travel reimbursements to eligible Veterans for their travel associated with examination, treatment and care. VHA maintains vendor and Veteran master records, derived from the information on payment claims submitted by VAMCs to the Fee central repository. In exchange, the Fee system produces reports relative to the information collected and the financial data received from FMS.[19]

Findings

Audits

VHA officially launched the VTP Office in 2011, and it assumed responsibility of BTP activities in 2012. Its primary responsibility of establishing policies and advising the medical centers on BTP has since evolved into a more consultative role. Although each VAMC centrally owns the overall operation of its local BTP and budget, as part of the VTP's consultative approach, it began conducting its own field audits of BTPs at VAMCs throughout VHA. Their audits include a review of payment processing system adjudication, eligibility determinations, and other business aspects with the goal to provide aid in areas of noncompliance. VTP conducts audits at VAMCs annually by invitation, and at VAMCs whose IPERA audit results warrant a closer review of their operations. On average, they complete seven to eight audits annually. Approximately five are by invitation and the remaining are those with IPERA issues.

Independent of the VTP Office, the VHA Office of Finance Improper Payments and Analysis (IPA) team conducts reviews of VAMCs. OMB Circular A-123, Appendix C defines statistically valid and rigorous plans as obtaining a plus or minus 3 percent or better margin of error at the 95th percentile confidence level for the improper payment percentage estimate.[20] To achieve this requirement, IPA contracts with an external agency and relies on a qualified statistician to develop the estimation methodology and perform the extrapolation and analysis of test results. Administrations and Staff Offices extract all data and send test results to the statistician for estimation and projection of annual improper payments. IPA submits detailed results, including extensive

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[18] VistA, in addition to maintaining patient clinical records, is VHA's decentralized system utilized for patient billing and collection transactions. Each VAMC has its own instance of VistA that must be separately maintained and updated. VistA contains the detailed subsidiary records that support the FMS general ledger control accounts.

[19] https://vaww.vashare.oit.va.gov/sites/io/Products/VHA/FEE/SitePages/Home.aspx. Accessed August 31, 2018.

[20] Statistical validity refers to being based on unbiased randomized sampling and producing valid point estimates and confidence intervals around those estimates. OMB Circular A-123, Appendix C.

calculations, to Administration and Staff Office Chief Financial Officers, program Senior Accountable Officials, and Improper Payments Remediation and Oversight, by the statistician to demonstrate the statistical validity. Additionally, IPA has a Memorandum of Understanding with various program offices, including BTP, to have their auditors, more experienced with the program, review and audit payments. The IPA team reports and projects their findings in the AFR. In a May 2018 report, the Office of Inspector General (OIG) found that "the statistical methodology VA used to produce its improper payment estimates complied with OMB Circular A-123, Appendix C requirements."[21]

In addition, VA's OIG contracts with external entities to audit our financials. Under the Chief Financial Officers Act of 1990, independent auditors perform an audit of our financial statements to obtain reasonable assurance about whether they are free from material misstatement. In the 2017 AFR, a memorandum dated November 15, 2017, from the Assistant Inspector General for Audits and Evaluations states that they "contracted with the independent public accounting firm, Clifton, Larson, and Allen LLP, to audit VA's financial statements as of September 30, 2017."

The auditors noted VA was noncompliant with IPERA for FY 2016, as reported by OIG since 2012. The auditor's opinion on VA financial statements is that the financial statement "present fairly, in all material respects, the financial position of the VA Franchise Fund as of September 30, 2017, and its consolidated net costs, changes in net position, and the combined budgetary resources for the years then ended, in accordance with U.S. generally accepted accounting principles."[22]

On May 7, 2018, the OIG Office of Audits and Evaluations published its report, that found, "VHA allowed some beneficiaries using SMT to improperly claim and receive Beneficiary Travel (BT) mileage reimbursements due to a lack of management controls," and recommended VHA "establish controls to mitigate the risk of fraudulent or improper payments." OIG concluded that "VHA management needs to strengthen oversight controls for the Beneficiary Travel Program to ensure Beneficiary Travel Office staff comply with SMT eligibility policies, prevent improper payments for SMT services, reduce SMT expenditures on ambulance services, and prevent payment of mileage reimbursement to SMT users for the same appointments." VHA concurred with OIG's recommendations and actions are underway with a target completion date of December 2018.[23] The 2017 IPERA review of a sample of VHA's FY 2016 claims showed over $996,000 was in error. Of that amount, $164,065 (36.62 percent) constituted a monetary loss to the Government. In the absence of proper management controls VHA will continue to waste funds by making improper BT payments that result in monetary loss.

There is no law, rule, or regulation that requires the VTP to audit the BTPs at VAMCs. However, internal and external entities conduct audits of the BTP annually. VHA relies

[21] OIG, Office of Audits and Evaluations, *VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017,* May 15, 2018.
[22] Department of Veterans Affairs Agency Financial Report Fiscal Year 2017.
[23] OIG, Office of Audits and Evaluations, VHA *The Beneficiary Travel Program, Special Mode of Transportation Eligibility and Payment Controls*, May 7, 2018.

on contracted auditing firms and OIG's Office of Audits and Evaluations to assure Congress that our reports of improper payments are accurate and meet statistical requirements.

Leadership Actions

We have an action plan in progress in response to OIG's recommendations for FY 2016 and FY 2017 following their audit of our compliance with IPERA. Of the six OIG recommendations for FY 2017 (three repeated from FY 2016, and two of which discuss beneficiary travel), they have closed two and partially closed two. We are continuing to address the open partial and full recommendations. However, VHA's legacy core financial management and general ledger system, FMS, was implemented in 1992. Since that time, Federal financial reporting requirements have become more complicated, and the level of financial information needed by management, Congress, and other oversight bodies has become increasingly demanding and complex. FMS' outdated chart of accounts, incorrect budget mapping tables, accounting attributes (Direct vs. Reimbursable, Federal vs. non-Federal, etc.) and transaction codes are not United States Standard General Ledger (USSGL) compliant.[24] Due to FMS' limited functionality to meet current financial management and reporting needs, VHA utilizes another application, the Management Information Exchange (MinX) system, to consolidate general ledger activities from FMS and create financial statements for external reporting. However, this process still requires significant manual intervention and workarounds to ensure accuracy. These limitations increase the risk of errors in the financial reporting process and become more apparent over time as additional reporting requirements continue to accumulate.

Reports to Congress of Inaccurate Payments

FY 2017 actual improper payment rates are based on FY 2016 data, per OMB guidance. We calculate and publish our actual improper payment rates in our annual AFR. In our FY 2017 AFR, we stated we had approximately $10.7 billion in improper payments; 223.76 million of which were BT payments.[25] OIG conducted their review to determine whether we complied with the requirements of the IPERA for FY 2017. Their report showed we reported improper payment estimates totaling $10.66 billion in our FY 2017 AFR, almost twice the FY 2016 reported amount of $5.49 billion. The net increase was primarily the result of VHA adding three programs susceptible to significant improper payments as well as reporting higher improper payments for five VHA programs. OIG found we met four of six IPERA requirements for FY 2017 by publishing the AFR, performing risk assessments, reporting improper payment estimates, and providing information on corrective action plans. They determined that although we reported improper payment estimates as required, the estimates for two programs and activities (Post-9/11 GI Bill and Supplies and Materials) could improve. The IPERA reporting requirements OIG found with which we did not comply are:

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[24] USSGL provides a uniform chart of accounts and technical guidance for standardizing Federal agency accounting.
[25] Department of Veterans Affairs AFR FY 2017.

- the gross improper payment rate of less than 10 percent for each program and activity that had an improper payment estimate in its FY 2017 AFR. BT (among other programs) exceeded the 10 percent threshold; and

- the annual reduction targets for BT (among other programs) have not met reduction targets for 3 consecutive FYs and are repeat findings.

We report SMT improper payments in our AFR under the BTP; as a component of the BTP, there should be no expectation for us to report SMT improper payments separately.

OIG recommended that VHA: 1) develop a timeline; and 2) implement steps to reduce improper payments under the 10 percent IPERA threshold for the BTP. We concur with OIG's recommendations and actions are underway with a target completion date of December 2018.

VA did not fail to measure improper payments. The responsibility is to estimate the annual amount of improper payments and report the estimates in our annual report along with plans and targets to reduce them. Each year we have met our reporting responsibility. However, our challenge has been implementing effective, sustainable operations to decrease avoidable improper payments. Moreover, the data extrapolated by the auditing firms are only as good as the system that contains the data. From 2012 to 2017, OIG has found us noncompliant with the respective Improper Payments Acts. Although we use another application to generate data for external reporting, this process still requires significant manual intervention and workarounds to ensure accuracy.

Conclusions for Allegations 3, 4, and 5

- We **do not substantiate** that, "the VTP has not required audits of VAMC's BTP payments, instead auditing only the sites that volunteer to participate, resulting in grossly inaccurate reports of improper payments to Congress (as required by IPERA)."

- There is no law, rule, or regulation that requires the VTP to audit the BTPs. However, both internal and external entities audit our BTPs annually.

- We **do not substantiate** that VA leadership failed to take appropriate action to address the above issue when put on notice by Whistleblower in approximately November 2016.

- VA leaders have devised action plans annually in response to OIG's annual evaluations and, although there have been some improvements, the financial software program in place does not meet government compliance and is vulnerable to errors.

- We **do not substantiate** that VA failed to properly measure and report to Congress improper payments for SMT under the VTP BTP because there is no specific data related to SMT. VA reports SMT improper payments in its AFR under the BTP.

- In the absence of proper management controls, VHA will continue to waste funds by improperly making BT payments that result in a monetary loss.

Recommendation to VHA

6. Address the open OIG recommendations, and, in the absence of a reliable and current financial management system, implement efforts to ensure the existing system supports an environment where improper reimbursements are prevented, or detected and corrected in a timely manner. If it is not possible to improve the existing system, explore options for a replacement.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that VISN 6 may have violated law, rule, or regulation, engaged in gross mismanagement and a gross waste of funds by the VA. In particular, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We did not find violations of VA and VHA policies; however, we found that a gross waste of funds existed within VHA related to improper BT payments.

Attachment A

VA Agency Financial Report Fiscal Year 2017.

VA Billing Fact Sheet for VA Community Care Programs, July 2017.

VA Handbook 1601B.05, Beneficiary Travel, July 21, 2010.

VA News Release. VA Announces Community Care Call Center to Help Veterans with Choice Program Billing Issues, March 14, 2016.

VA Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care, October 30, 2015.

VHA Handbook 1601B.05, Beneficiary Travel, July 21, 2010.

OIG, Office of Audits and Evaluations, *VA's Compliance with the Improper Payments Elimination and Recovery Act for FY 2017,* May 15, 2018.

OIG, Office of Audits and Evaluations, VHA *The Beneficiary Travel Program, Special Mode of Transportation eligibility and Payment Controls,* May 7, 2018.

Office of Management and Budget Circular A-123, Appendix C.

https://www.va.gov/opa/publications/benefits_book/Chapter_1_Health_Care_Benefits.asp. Accessed June 15, 2018.

https://vaww.va.gov/choice. Accessed June 15, 2018.

https://www.govregs.com/regulations/38/17.1535. Accessed June 15, 2018.

https://vaww.vashare.oit.va.gov/sites/io/Products/VHA/FEE/SitePages/Home.aspx. Accessed August 31, 2018.

Attachment B
Priority Groups

Priority groups have been established to manage the provision of care to all enrolled Veterans. Upon application, each Veteran will be placed into the highest priority group for which they are eligible based upon verification of the information provided in the VA Form 10-10EZ. A description of priority groups follows:

A. Priority Group 1. Priority Group 1 consists of Veterans with a singular or combined rating of 50 percent or greater based on one or more service connected disabilities or unemployability.

B. Priority Group 2. Priority Group 2 consists of Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service connected disabilities.

C. Priority Group 3. Priority Group 3 consists of:

(1) Veterans who are former POWs;

(2) Veterans awarded the Purple Heart or the Medal of Honor;

(3) Veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service connected disabilities;

(4) Veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty;

(5) Veterans who receive disability compensation under 38 U.S.C. 1151;

(6) Veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such Veterans' continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. 1151;

(7) Veterans whose entitlement to disability compensation is suspended because of the receipt of military retired pay; and

(8) Veterans receiving compensation at the 10 percent rating level based on multiple non-compensable service connected disabilities that clearly interfere with normal employability.

D. Priority Group 4. Priority Group 4 consists of:

(1) Veterans who receive increased pension based on their need for regular aid and attendance (A&A);

(2) Veterans who receive increased pension by reason of being permanently housebound (HB); and

(3) Veterans who are determined to be catastrophically disabled (CD), unless the Veteran qualifies for placement in a higher priority group, by the Chief of Staff (or equivalent clinical official) at the VA medical facility where they were examined.

E. Priority Group 5. Priority Group 5 consists of Veterans who are determined to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a). To meet the criteria for Priority Group 5, a Veteran must be eligible based on financial information. As a result of amendments to 38 U.S.C. 1722(f)(1) in section 705 of Pub. L. 112-154, HEC will annually confirm a Veteran's continued financial eligibility status by verifying his or her income with Federal Tax Information (FTI) obtained from the Internal Revenue Service (IRS) and Social Security Administration (SSA).

F. Priority Group 6. Priority Group 6 consists of:

(1) Veterans of the Mexican border period or of World War I;

(2) As provided and limited in 38 U.S.C. 1710(e), Veterans solely seeking care for:

(a) A disorder associated with exposure to a toxic substance or radiation;

(b) A disorder associated with service in the Southwest Asia theater of operations during the Gulf War (the period between August 2, 1990, and November 11, 1998); or

(c) Any illness associated with service in combat during a period of war after the Gulf War or during a period of hostility after November 11, 1998, if the Veteran was discharged or released from active service on or after January 28, 2003. NOTE: Veterans described in this paragraph who are not eligible for placement in a higher priority group are eligible for VA health care benefits for a period of five (5) years beginning on the date of the individual Veteran's discharge or release from the active military, naval or air service. This 5-year enrollment period begins on the date of such discharge or release, or in the case of multiple call-ups, the most recent discharge or release date. See 38 U.S.C. 1705(a)(6), 1710(e)(3)(A); 38 C.F.R 17.36(b)(6). Note however that if a Veteran was discharged or released from the active military, naval, or air service after January 1, 2009, and before January 1, 2011, but did not enroll to receive hospital care, medical services, or nursing home care during the 5-year period described above, the Veteran has, by law, an additional 1-year period within which to apply for enrollment in VA's health care system as a combat-theater Veteran. This additional 1-year period starts on February 12, 2015. After a combat-theater Veteran's period of enrollment in Priority Group 6 ends, the Veteran will remain continuously enrolled in VA's health care system but must be moved to the appropriate enrollment priority group.

(3) Veterans who served on active duty at Camp Lejeune in North Carolina for not less than 30 days during the period beginning on August 1, 1953 and ending on December 31, 1987 for any of the 15 medical conditions specified in 38 U.S.C. 1710(e)(1)(F). NOTE: Veterans who would otherwise be enrolled as Priority Group 7 or 8 without the Camp Lejeune eligibility will remain in that priority group. Once changes are made to the VistA system, these Veterans will be placed in Priority Group 6, but may be charged copayments for care not related to the specified Camp Lejeune illnesses and conditions based on their status as a Priority Group 7 or 8 Veteran, as applicable.

(4) Veterans with zero percent service connected disabilities who are nevertheless compensated, including Veterans receiving compensation for inactive tuberculosis;

G. Priority Group 7. Priority Group 7 consists of Veterans who agree to pay to the United States (U.S.) the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g) if their income (including the income of their spouse and dependents) for the previous year constitutes "low income" under the geographical income limits established by the U.S. Department of Housing and Urban Development for the fiscal year that ended on September 30 of the previous calendar year. To avoid a hardship to a Veteran, VA may use the projected income for the current year of the Veteran, spouse, and dependent children if the projected income is below the "low income" limit referenced in 38 CFR 17.36(b)(7). This group is further prioritized into the following sub-groups:

(1) **Sub-priority Group A**. Sub-priority group A consists of non-compensable zero percent service connected Veterans who are enrolled on a specified date announced in a Federal Register document promulgated under 38 CFR 17.36(c) who subsequently do not disenroll;

(2) **Sub-priority Group B**. Sub-priority group B consists of non-service connected Veterans who are enrolled on a specified date announced in a Federal Register document promulgated under 38 CFR 17.36(c) who subsequently do not disenroll;

(3) **Sub-priority Group C**. Sub-priority group C consists of non-compensable zero percent service connected Veterans not included in sub-priority A; and

(4) **Sub-priority Group D.** Sub-priority group D consists of non-service connected Veterans not included in sub-priority B.

H. Priority Group 8. Priority Group 8 consists of Veterans with gross household income above the means test (MT) threshold and the geographic means test (GMT) income threshold who agree to pay the U.S. the applicable copayments determined under 38 U.S.C. 1710(f) and 1710(g). Effective June 15, 2009 (see 74 FR 22832), VA relaxed income restrictions for Priority Group 8 Veterans by 10 percent to increase income thresholds for health care benefits. This group is further prioritized into the following sub-groups:

(1) Veterans Eligible for Enrollment.

(a) Sub-priority group A consists of non-compensable zero percent service connected Veterans who were enrolled on January 17, 2003, or who are moved from a higher priority group or sub-group due to no longer being eligible for inclusion in such priority group or sub-group and who subsequently do not request disenrollment;

(b) Sub-priority group B consists of non-compensable zero percent service connected Veterans who were enrolled on or after June 15, 2009, and whose income is not greater than ten percent more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher;

(c) Sub-priority group C consists of non-service connected Veterans who were enrolled on January 17, 2003, or who are moved from a higher priority group or sub- group due to no longer being eligible for inclusion in such priority group or sub-group and who subsequently do not request disenrollment; and

(d) Sub-priority group D consists of non-service connected Veterans who were enrolled on or after June 15, 2009, and whose income is not greater than 10 percent more than the income that would permit their enrollment in Priority Group 5 or Priority Group 7, whichever is higher.

(2) Veterans Not Currently Eligible for Enrollment who Applied for Enrollment on or after January 17, 2003.

(a) Sub-priority group E consists of non-compensable zero percent service connected Veterans who are eligible for care of their service connected condition only who do not meet the criteria above; and

(b) Sub-priority group G consists of non-service connected Veterans who do not meet the preceding criteria.

Key to Investigators and Interviewees

[redacted] M.D., FACP, FACHE, Medical Inspector
[redacted] NP, Clinical Program Manager
[redacted] Investigator, VA Office of Accountability and Whistleblower Protection
[redacted] Former Asheville Director, June 2010 – July 2017
[redacted] MD, Chief of Staff, Asheville
[redacted] Associate Director for Patient Care Services/Chief Nurse Executive, Asheville
[redacted] National Program Director, Veteran Transportation Service
[redacted] Veteran Transportation Program Deputy Director
[redacted] Chief, Health Administration Service (HAS), Asheville
[redacted] Assistant Chief, HAS, Philadelphia
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[redacted] Community Care Supervisor
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