Report No. DODIG-2013-135

INSPECTOR GENERAL

U.S. Department of Defense

SEPTEMBER 18, 2013

The Department of Defense and Veteran Affairs Health Care Joint Venture at Tripler Army Medical Center Needs More Management Oversight

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Results in Brief

The Department of Defense and Veteran Affairs Health Care Joint Venture at Tripler Army Medical Center Needs More Management Oversight

September 18, 2013

Objective

Our audit objective was to determine whether the Master Sharing Agreement (MSA) and Joint Policies governing claims and reimbursement between Department of Veterans Affairs (VA) and DoD for health care services at Tripler Army Medical Center (TAMC) were operating effectively.

Findings

The MSA and Joint Policies were not effective to obtain timely reimbursement for health care services provided. Specifically, the MSA and Joint Policies did not comply with DoD Regulations, deliver an adequate authorization process, or provide an effective modification process to revise local policies. These conditions contributed to $26.2 million out of $73.2 million in medical services provided to Veterans Affairs Pacific Islands Health Care System beneficiaries from FY 2009 through FY 2012 not being reimbursed, $3.7 million in claims not billed in accordance with DoD regulations, and another $3.7 million in uncompensated care.

This occurred because DoD management did not provide adequate oversight governing this Joint Venture. As a result of the ineffective MSA and Joint Policies governing the interagency agreement, TAMC cannot ensure that the military treatment facility can meet the

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Findings Continued

reimbursement requirement of Section 8111, Title 38, United States Code, "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources." Furthermore, without a mutual solution between DoD and the Department of Veterans Affairs to address these longstanding problems, the burden of about $26.2 million in delinquent debt, $3.7 million in unbilled claims, and $3.7 million in uncompensated care will continue to grow. (See Appendix E for details on potential monetary benefits.).

Recommendations

Among other recommendations, we recommend TAMC request the required waiver from the Under Secretary of Defense (Comptroller) and elevate issues to U. S. Army Medical Command (MEDCOM); MEDCOM request DoD/VA Program Coordination Office to review the reimbursement policy; and Assistant Secretary of Defense (Health Affairs) require the DoD/VA Program Coordination Office present the issues cited to the appropriate levels within the Health Executive Council for resolution.

Management Comments

The Assistant Secretary of Defense (Health Affairs) comments were partially responsive to the one recommendation. The Chief of Staff, MEDCOM, responding on behalf of the Commander, MEDCOM, and Commander, TAMC, comments were responsive to 9 of 10 recommendations and partially responsive to 1 of 10 recommendations. We request that the Secretary of Defense (Health Affairs) and Chief of Staff, MEDCOM, provide revised comments to the final by October 18, 2013. Please see the Recommendations Table on the back of this page.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Assistant Secretary of Defense (Health Affairs)	3	
Commander, U.S. Army Medical Command		2.a, 2.b
Commander, Tripler Army Medical Center	1.e	1.a, 1.b, 1.c, 1.d, 1.f, 1.g, 1.h

*Please provide comments by October 18, 2013.

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

September 18, 2013

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: The Department of Defense and Veteran Affairs Health Care Joint Venture at Tripler Army Medical Center Needs More Management Oversight (Report No. DODIG-2013-135)

We are providing this report for your review and comment. DoD management did not provide adequate oversight governing the Joint Venture at Tripler Army Medical Center. As a result, without a mutual solution between DoD and the Department of Veterans Affairs to address the longstanding problems, the burden of about $26.2 million in delinquent debt, $3.7 million in unbilled claims, and $3.7 million in uncompensated care will continue to grow. During the audit, we identified $33.6 million in potential monetary benefits that could be used to meet future requirements. We considered management comments on a draft of this report when preparing the final report.

DoD Directive 7650.3 requires that recommendations be resolved promptly. The Assistant Secretary of Defense (Health Affairs) comments for Recommendation 3 were partially responsive. Although we did redirect this recommendation, we request additional comments on this recommendation by October 18, 2013. The Chief of Staff, U.S. Army Medical Command, responding on behalf of the Commander, U.S. Army Medical Command, and Commander, Tripler Army Medical Center, agreed with recommendations 1.a, 1.b, 1.c, 1.d, 1.f, 1.g, 1.h, and 2.a; however; comments on Recommendations 1.e were only partially responsive. Although the Chief of Staff, U.S. Army Medical Command did not agree with recommendation 2.b, we deemed his response on actions to be taken responsive. Therefore we request additional comments on Recommendation 1.e by October 18, 2013.

If possible, send a PDF file containing your comments to audcolu@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We cannot accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 601-5945 (DSN 329-5945).

Lorin T. Venable

Lorin T. Venable, CPA
Assistant Inspector General
Financial Management and Reporting

Contents

Introduction

Objective

Our objective was to determine whether the Master Sharing Agreement (MSA) and Joint Policies governing claims and reimbursement between Department of Veterans Affairs (VA) and DoD for health care services at Tripler Army Medical Center (TAMC) were operating effectively. See Appendix A for the scope and methodology and prior coverage related to the audit objective.

Background

Tripler Army Medical Center and the Joint Venture With the Department of Veterans Affairs Pacific Island Health Care System

TAMC, home of the Pacific Regional Medical Command (PRMC), is the only Federal tertiary care hospital in the Pacific Basin. TAMC supports 264,000 local active duty and retired military personnel, their families, and veteran beneficiaries. TAMC supports an additional 171,000 military personnel, family members, veteran beneficiaries, residents of nine U.S. affiliated jurisdictions, and forward-deployed forces in more than 40 countries throughout the Pacific.

In 1992, the Under Secretary of the Army signed the initial Joint Venture agreement between TAMC and Veterans Affairs Pacific Islands Health Care System (VAPIHCS). The vision for the Joint Venture agreement is to be the model DoD/VA integrated comprehensive health care system in the 21st century. According to the agreement, TAMC billed VAPIHCS for medical services totaling $18.7 million for FY 2009, $21.0 million for FY 2010, $18.2 million for FY 2011, and $15.3 million for FY 2012[1].

Requirements for Health Care Resources

Section 8111, Title 38, United States Code, "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources," January 5, 2009[2], states that the Secretary of VA and the Secretary of Defense will enter into agreements and contracts for the mutually beneficial use or exchange of the health care resources of the VA

[1] The values billed to VAPIHCS represent net billings as of October 1, 2012. An additional $2.8 million for FY 2011 through FY 2012 was billed to VAPIHCS for professional fees; however VAPIHCS was not required to pay these bills, pending resolution. Professional fees are categorized as charges for attending physicians, consulting physicians, or both.

[2] The January 3, 2012, version of Section 8111, Title 38, United States Code contains the same language as the January 5, 2009, version.

and DoD. The goal is to improve the access to, and quality and cost effectiveness of, the health care provided by the VA and the Military Health System to the beneficiaries of both Departments.

Furthermore, reimbursement under any sharing agreement entered into is based on a methodology on which the two Secretaries agree. The methodology should provide appropriate flexibility to the heads of the facilities concerned, to take into account local conditions and needs and the actual cost to the providing agency's facility of the health care resources provided. Facilities that provided the care or services will receive the reimbursed funds. According to the agreements, an agency will be reimbursed for the cost of the health care resources provided. Furthermore, the rate for such reimbursement will be determined in accordance with the methodology on which the two Secretaries agree.

DoD/VA Program Coordination Office

The DoD Veteran Affairs Program Coordination Office (DVPCO) serves as the central entity within Health Affairs/TRICARE Management Activity to monitor all VA/DoD Health Care Resource Sharing activities, to include Health Information Management/Technology, Financial Management, Clinical Activities, National Level Interagency Agreements, TRICARE/VA Contractor Relationships, Joint Ventures, and Health Systems Studies. As of FY 2013, there were 10 Joint Ventures.

National Agreements for Inpatient and Outpatient Billing Between DoD and VA

Two memorandums establish the current national agreement between VA and DoD for inpatient and outpatient reimbursement rates. Both "Department of Veterans Affairs-Department of Defense Health Care Resource Sharing Rates – Billing Guidance for Inpatient Services," August 2006, and "Outpatient Billing Guidance for Department of Defense/Veterans Affairs Direct Sharing Agreements for Health Care," August 2009, provide guidance on billing rates to be used for VA and DoD sharing agreements. Facilities are to bill services provided under the sharing agreements at the TRICARE/Civilian Health and Medical Program of the Uniformed Services maximum allowable charge rates less 10 percent, when a rate is available. Both memorandums further identify TAMC as a facility that can negotiate rates other than the 10-percent discount to reflect the value of nonmonetary contributions such as shared space or staff.

Master Sharing Agreement Between TAMC and VAPIHCS

The intent of the MSA effective January 1, 2008, through December 31, 2013, is to provide an instrument for sharing all health care resources between VAPIHCS and TAMC where demand and capability exist, provided such sharing does not delay or deny care to the primary population of each agency. The sharing agreement defines eligibility for care, types of services available, responsibilities of both parties, and procedures for development or modification of joint policies. Both the Commanding General of TAMC and the Director of VAPIHCS signed and dated the sharing agreement.

DoD Financial Management Regulation, Volume 4, Chapter 3, "Receivables"

DoD Regulation 7000.14-R, "DoD Financial Management Regulation" (DoD FMR), volume 4, chapter 3, requires that "receivables must be recognized when corresponding revenue is earned and collected when due." In addition, regarding intragovernmental receivables, DoD performing activities will not perform reimbursable work for another Federal Agency that is 90 days or more in arrears in payment of previous reimbursable billings. The Office of the Under Secretary of Defense may waive this restriction if doing so is in the national interest.

Review of Internal Controls

DoD Instruction 5010.40, "Managers' Internal Control Program (MICP) Procedures," July 29, 2010, requires DoD organizations to implement a comprehensive system of internal controls that provides reasonable assurance that programs are operating as intended and to evaluate the effectiveness of the controls. We identified internal control weaknesses associated with the MSA and Joint Policies governing claims and reimbursement between the Department of VA and DoD for health care services in accordance with DoD Instruction 5010.40. Commander TAMC, Commander U.S. Army Medical Command (MEDCOM), and Director DVPCO did not comply with regulations and policies to obtain timely reimbursement for health care services provided to VAPIHCS beneficiaries. We will provide a copy of the report to the senior official responsible for internal controls in the Department of the Army.

Finding

Inadequate Oversight of Policies Has Resulted in Rising Delinquent Interagency Debt

The MSA[3] and Joint Policies governing claims and the reimbursement methodology were not effective to obtain timely reimbursement for health care services provided to VAPIHCS beneficiaries. Specifically, the MSA and Joint Policies did not:

- comply with the DoD FMR,
- deliver an adequate authorization process, or
- provide an effective modification process to revise local policies.

These conditions contributed to $26.2 million out of $73.2 million in medical services provided to VAPIHCS beneficiaries from FY 2009[4] through FY 2012 not being reimbursed, $3.7 million in unbilled claims, and $3.7 million in uncompensated care. This occurred because prior and current management at TAMC, MEDCOM, and DVPCO did not provide adequate oversight governing this joint venture. As a result, the policies governing the interagency agreement at TAMC have not ensured that the military treatment facility can meet the reimbursement requirement of Section 8111, Title 38, United States Code, "Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources." Furthermore, without a mutual solution to address longstanding problems, the burden of about $26.2 million in delinquent debt, $3.7 million in unbilled claims; and $3.7 million in uncompensated care will continue to grow,[5] which adversely affects TAMC's financial ability to continue providing the best quality care. Although the delinquent debt is still an issue, MEDCOM stated that VA had paid down the delinquent debt to $13.3 million as of March 15, 2013.

[3] We examined the current MSA, effective from January 1, 2008, through December 31, 2013. We did not examine any earlier MSAs.

[4] We chose to start our review with FY 2009 claims because it coincided with the implementation of Enhanced-Document and Referral Management System (E-DR).

[5] As of February 19, 2013, TAMC reported $4.5 million in FY 2013 delinquent debt, with no payment to a FY 2013 claim made, and $611,409.83 in professional fees (see definition on page 14) that TAMC is required to bill, but VA is not required to pay, pending resolution.

Master Sharing Agreement and Joint Policies Contributed to Rising Delinquent Debt, Unbilled Claims, and Uncompensated Care

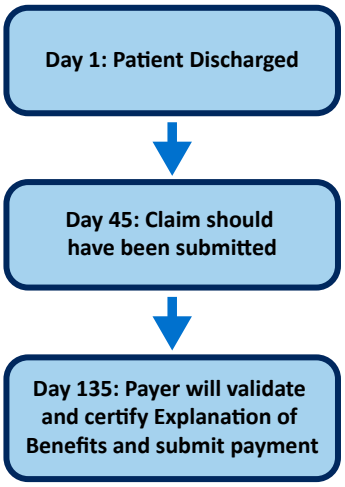
The MSA and Joint Policies were not effective to obtain reimbursement of health care services provided to VAPIHCS beneficiaries from FY 2009 and FY 2012. The agreement intended to share health care resources between VAPIHCS and TAMC where demand and capacity exist, provided such sharing did not delay or deny care to the primary population of each agency. Joint policies such as Joint Policy #08-016, "Claims and Payments between TAMC and VAPIHCS," March 2008; Joint Policy for Reimbursement FY 2012; and Joint Policy #08-020, "Authorization Guidelines for Outpatient Care," March 2008 supplement the MSA and act as the standard operating procedures of the Joint Venture. However, the MSA and the joint policies did not comply with DoD FMR, deliver an effective authorization process, or provide an effective modification process.

Joint Policy Compliance With DoD Financial Management Regulation

Joint Policy #08-016 was not effective to obtain timely reimbursement of $26.2 million or bill $3.7 million in health care services provided to VAPIHCS beneficiaries; therefore, Joint Policy #08-016 did not comply with DoD FMR. Two systemic instances of noncompliance with DoD FMR policy existed within the Joint Policy and claims processing. First, the TAMC claims process was not in compliance with DoD FMR volume 4, chapter 3, "Receivables" guidance regarding the requirement for payment from another Federal agency within 90 days. Second, TAMC did not record receivables appropriately. DoD FMR volume 4, chapter 3, "Receivables," subsection 030102 states that receivables must be recognized when corresponding revenue is earned and collected when due.

Joint Policy #08-016 and the FY 2012 Joint Policy for Reimbursement require the processing of claims to start the day of patient discharge. Claims should then be submitted within 45 days and then paid within 90 days of submission; however this processing of claims did not occur for millions of dollars in services rendered. See Figure 1 for a claims processing timeline.

Figure 1. Claims Processing Timeframe



Claims Were Not Reimbursed in a Timely Manner

TAMC continued to provide services to VAPIHCS beneficiaries even though millions of dollars in reimbursements were in arrears. For claims from FY 2009 through FY 2011, TAMC's management provided documentation showing past due balances as of October 1, 2012, of $1.3 million for FY 2009, $4.6 million for FY 2010, and $9.0 million for FY 2011. These past due balances were all beyond the 90-day payment requirement within the DoD FMR. Total amount unpaid for FY 2012 was $11.3 million. Table 1 shows TAMC's account for VAPIHCS delinquent debt by fiscal year.

Table 1. VAPIHCS Delinquent Debt as of October 1, 2012 (millions)

Fiscal Year	Net Billed	Net Paid	Unpaid
FY 2009	$18.7	$17.5	$1.3
FY 2010	21.0	16.3	4.6
FY 2011	18.2	9.1	9.0
FY 2012	15.3	4.0	11.3
Totals	**$73.2***	**$46.9**	**$26.2**

*The total does not sum because of rounding.

For the FY 2012 data provided, 15,207 unpaid claims valued at $6.1 million were more than 90 days in arrears as of October 11, 2012.

Paid claims were not reimbursed in a timely manner. For FY 2012, TAMC did not receive its first payment, valued at $25, from VAPIHCS for services provided until May 2012, despite billing VAPIHCS for $9.4 million up to that point. We reviewed fifteen paid claims valued at $575,336, and receipt of payments for these 15 claims from VAPIHCS took an average of 159 days. For example, TAMC transmitted claim 0052-12-0020751 to VAPIHCS on December 27, 2011. However, TAMC did not receive the $33,686 payment until August 10, 2012, 227 days after transmittance.

Receipt of payments from these 15 claims from VAPIHCS took an average of 159 days.

As a result, TAMC was not in compliance with DoD FMR by continuing to perform reimbursable work for another Federal agency that was 90 days or more in arrears. TAMC management was aware of these unpaid balances and in the interest of patient safety knowingly disregarded the DoD FMR volume 4, chapter 3, requirement to terminate service because of payments in arrears to VAPIHCS. However, TAMC management stated that it was unaware of the requirement to obtain a waiver from the Office of the Under Secretary of Defense. TAMC management did not provide adequate oversight in resolving this problem. TAMC management should request the waiver from the Office of the Under Secretary of Defense to continue providing service to another agency more than 90 days in arrears and working with VAPIHCS to resolve the delinquent debt in a reasonable amount of time.

Billing and Recording Receivables

TAMC management identified more than 14,000 claims for FY 2012, valued at $3.7 million, which had yet to be billed and recorded as a receivable in accordance with the DoD FMR. TAMC personnel described these claims in two ways: claims containing billing or coding errors and claims that were unauthorized. Table 2 illustrates these claims.

Table 2. FY 2012 Unbilled Claims

Type	Claims	Amount*
Unbilled – billing and coding errors	3,197	$ 242,475
Unbilled – unauthorized	11,034	3,449,918
Total	**14,321**	**$ 3,692,392**

*The amounts are estimates, because the actual value of the claim cannot be computed until the claim is recorded as a "receivable" and all applicable discounts are applied. The total does not sum because of rounding.

We reviewed 30 of the 14,321 claims; these 30 claims were valued at an estimated $1 million. We identified three problems with recording claims as a receivable when revenue was earned. First, TAMC management was not reviewing and correcting claims containing billing or coding errors in a timely manner. Second, TAMC management erroneously believed a VA authorization was a prerequisite to recording a receivable. Third, TAMC personnel disagreed internally about who was responsible to research and resolve claims containing authorization errors.

Timely Review of Claims Containing Billing and Coding Errors. TAMC management did not adequately oversee the unbilled claims containing billing or coding errors, resulting in $242,474 in claims not being recorded as receivables in accordance with DoD FMR volume 4, chapter 3. We reviewed 15 claims, valued at $103,717, containing billing or coding errors. TAMC management stated that after our request to review the 15 claims, it assigned staff to begin researching, reviewing, and recording some of the claims as receivables. As Figure 1 shows, a claim should be submitted within 45 days of patient discharge. However, for these claims, the correction and recording of a receivable was performed in an untimely fashion. For example, Claim 0052-12-0018075 contained a discharge date of December 12, 2011. The claim was initially created on December 15, 2011, and was not recorded as a receivable until October 26, 2012, 316 days later. The claim, valued at $1,123, had an error code tied to it.

Although TAMC had begun reviewing and correcting some of these errors for claims before our site visit, the reviewing and correcting were not performed in a timely fashion. The remainder of the claims containing billing or coding errors should be reviewed, researched, and correctly recorded as receivables.

Recording Unauthorized Claims. TAMC management did not adequately oversee the unbilled unauthorized claims, resulting in $3,449,918 in claims not recorded as receivables in accordance with DoD FMR volume 4, chapter 3. We reviewed 15 claims, valued at $922,676, containing authorization errors. TAMC management stated that it misinterpreted a 2009 MEDCOM policy that stated that the accounts receivable will become recognizable when the bill or claim is invoiced. TAMC management erroneously believed that VA authorization was required to record a receivable.

Internal Disagreements. Furthermore, TAMC personnel did not agree whether the billing department or the authorization center was responsible for researching, reviewing, and correcting the claims containing authorization errors. As a result of the misinterpretation of guidance and internal disagreement, the claims remained unrecorded as a receivable. For example, Claim 0052-12-0023663 contained a discharge date of November 15, 2011. The claim was initially created on December 28, 2011, and as of our site visit, October 30, 2012, a date 307 days later, had not yet been recorded as a receivable. The claim, valued at $171,207, had an authorization error tied to it.

The claim was initially created on December 28, 2011, and as of our site visit, October 30, 2012, a date 307 days later, had not yet been recorded as a receivable.

Inadequate management oversight caused claims to remain unbilled for extensive periods of time. TAMC management needs to review, research, and record the unauthorized claims as receivables; revise the claims processing policy to comply with DoD FMR; and identify the roles and responsibilities associated with the processing of claims.

Authorization Process Hinders Processing and Reimbursement

The joint policies did not deliver an adequate authorization process to perform timely processing and reimbursement of claims for services provided to VAPIHCS beneficiaries. Specifically, 11,034 claims, valued at $3.45 million, were unauthorized in FY 2012 as of October 11, 2012, because of missing authorizations or data quality problems, which delayed reimbursement.

In September 2008, VAPIHCS awarded a contract to provide the Enhanced-Document and Referral Management System (E-DR) to both the VAPIHCS and TAMC. This system is composed of five modules, two of which are the Referral Management module and the Billing Module Accounts Receivable Management System-Professional (ARMS-Pro). TAMC personnel use the ARMS-Pro module as their primary system to bill VAPIHCS beneficiaries. The award not only granted VAPIHCS contract oversight over E-DR, which also included contract oversight over TAMC's billing module ARMS-Pro, but also provided only VAPIHCS personnel and not TAMC personnel the administrative privileges to approve authorization numbers needed to process claims within ARMS-Pro. E-DR provides a method to match each VA authorization number or referral to the appointment. This process provides the users in both agencies increased

visibility to determine status of a particular claim, to include the proper authorization. E-DR reconciles patient information from the ARMS-Pro billing module against the E-DR Referral Management module to accurately account and bill VAPIHCS claims. Without a valid VAPIHCS authorization tied to a claim, claims failed to clear TAMC's E-DR ARMS-Pro billing module. See Table 3 for a detailed description of the reasons claims remained unauthorized.

Table 3. FY 2012 Claims Remaining Unauthorized as of October 11, 2012

Authorization Failure Code	Number of Claims	Amount (in millions)
Missing Authorization Number	7,536	$1.35
Data Quality	3,414	1.87
Other	84	0.22
Total	**11,034**	**$3.45***

*Total does not sum because of rounding.

Claims Missing Authorizations

For FY 2012, 7,536 claims valued at about $1.35 million were missing authorizations as of October 11, 2012. These claims encompassed outpatient care, urgent/emergent care, and inpatient care. Specific examples follow:

- **Outpatient Claims Were Missing Authorizations.** For FY 2012, 5,470 outpatient claims, valued at $858,192, were missing an authorization as of October 11, 2012. Joint Policy #08-020 provides guidance and establishes procedures for obtaining authorization for care of eligible VAPIHCS beneficiaries referred for, or seeking, outpatient treatment at TAMC. The policy states that TAMC will provide outpatient care[6] on a space-available basis to VA beneficiaries when referred and preauthorized. Furthermore, the Joint Policy for Claims and Payment between VAPIHCS and TAMC indicated that TAMC will bill services rendered on VA beneficiaries within 45 days of discharge. The E-DR subcontractor stated that outpatient claims that are missing an authorization primarily occur for the following two reasons: because the date of service falls outside the validity period for the authorization or because the clinic that provided treatment was not authorized. For example, control number 0052-12-0099217 identified a VAPIHCS beneficiary with an open authorization for cancer treatment

[6] Outpatient care is medical care or treatment that does not require an overnight stay in a hospital or medical facility, to include patients triaged as "urgent" or "emergent."

from December 2011 through May 2012. The next authorization began October 17, 2012; however, a pharmacy claim was identified on July 19, 2012, which fell outside the validity period for each authorization. As a result, the claim remained outstanding because TAMC officials indicated that VAPIHCS refused to back-date the authorization and reimburse TAMC for the pharmacy claim totaling $6,854.40. As of May 7, 2013, this claim remained unauthorized and not reimbursed.

- **Urgent/Emergent Claims Were Missing Authorizations.** For FY 2012, 1,949 urgent/emergent claims, valued at $202,995, were missing an authorization as of October 11, 2012. Joint Policy #08-020 states that VA beneficiaries seeking emergency care at a TAMC clinic will be treated and that VAPIHCS will be notified within 5 business days through the TAMC VA Referral Center of the encounter. The VA Referral Center will seek retrospective authorization from VAPIHCS for services rendered. VA beneficiaries seeking emergency care at TAMC will be triaged by the emergency room physician. TAMC management provided data from January 2010 to August 2012 showing that receiving the retrospective authorization took on average 111 days. Whether TAMC failed to notify VAPIHCS of the emergency encounter or VAPIHCS failed to provide the authorization remains in question; however, the untimely authorizations negatively affected TAMC reimbursement for urgent/emergent services rendered to VAPIHCS beneficiaries.

- **Inpatient Claims Were Missing Authorizations, Because No Formal Requirement To Obtain Such Authorizations Existed.** For FY 2012, 117 inpatient claims, valued at $292,263, were missing an authorization as of October 11, 2012. Unlike established guidance for outpatient services, established guidance to discuss inpatient services did not exist. Although no written guidance existed requiring a VAPIHCS authorization for inpatient care, the E-DR system required an authorization for a claim to be processed. As such, inpatient claims did not clear the E-DR authorization because one was not provided.

- **Claims for Services Rendered Missing Authorizations Were Deleted.** In addition to the 7,536 claims missing authorizations, E-DR ARMS-Pro contractor, Benefit Recovery Inc., provided us with a list of an additional 617 claims from FY 2010 through FY 2012, worth about $56,267, which were deleted from E-DR. TAMC officials indicated that

VAPIHCS refused to provide an authorization for the services. As a result, TAMC management decided to delete these claims, despite service being rendered.

To address the lack of authorizations for outpatient care, urgent/emergent care, and inpatient care, TAMC should request administrative privileges within E-DR to generate, adjust, or amend an authorization so that fewer claims would fall outside or between authorization periods and thereby elude reimbursement. These examples also present the possibility of endangering the patient's safety and health at TAMC because the burden of uncompensated care as a result of an ineffective authorization process limits resources and threatens TAMC's ability to care for all patients.

TAMC should also not be expected to absorb the costs of care rendered in good faith and associated with treating VAPIHCS beneficiaries. TAMC management needs to revise the authorization policies to allow TAMC the ability to properly bill VAPIHCS for services rendered to beneficiaries, regardless of whether VAPIHCS provides an authorization.

TAMC Management needs to reinstate the deleted claims and request from VAPIHCS an authorization, and if no authorization is received, bill VAPIHCS after 45 days for the services rendered.

Data Quality Concerns Prevented Timely Processing of Thousands of Claims

In FY 2012, of the 11,034 claims with authorization errors, 3,414 claims valued at $1.87 million contained data quality errors resulting in authorization failures as of October 11, 2012. These claims for services rendered to VAPIHCS beneficiaries contained data quality problems that prevented the claims from clearing the E-DR ARMS-Pro billing module and TAMC from receiving reimbursement. Examples of these errors include the following:

- **Missing Appointment Internal Entry Number Caused Authorization Failures.** 2,354 urgent/emergent claims worth $78,632 resulted in authorization failure illustrated in E-DR as "Invalid Search Criteria" as of October 11, 2012. These authorizations failed to process the E-DR ARMS-Pro billing module because claims were missing the required appointment Internal Entry Number. According to TAMC officials, for the authorization to link all medical procedures performed on the patient during the approved authorization period, TAMC requires an appointment Internal Entry Number when building claims. TAMC Management stated that these errors occurred because TAMC Clinical

staff are not linking an appointment Internal Entry Number to the appropriate appointment. However, TAMC management did not research or correct these errors. TAMC Management needs to review these authorization failures more timely to ensure that the required Internal Entry Number is properly linked to the appointment.

- **Level of Care (LOC) Authorization Failures.** TAMC failed to identify how LOC mismatch authorization errors[7] negatively affected TAMC's ability to collect on inpatient episodes of care for 908 claims worth about $1.8 million in FY 2012 as of October 11, 2012. TAMC management indicated that LOC authorization failures occur for the following two reasons: either billing methodologies supplied by TAMC and VAPIHCS-Utilization Management nurses differ for each specific inpatient episode of care, or, because of inconsistent methodologies, the E-DR system provides inaccurate information when a patient transfers between different LOCs at TAMC. TAMC officials provided a system change request, dated October 28, 2010, approved in December 2011, to correct this calculation in E-DR. These situations occurred because Joint Policy #08-020 for authorizations failed to standardize a shared methodology. TAMC Management needs to establish a standardized shared methodology when calculating inpatient LOC days under the interagency sharing agreement.

- **Social Security Number and Date of Birth Errors.** We identified 152 claims as of October 11, 2012 that remained outstanding, totaling $33,759, because of social security number and date of birth errors, resulting in authorization failures. TAMC Management was not able to determine why such errors remained unprocessed in the ARMS-Pro billing module; however, TAMC Management indicated that these errors may occur from TAMC personnel making transposition errors when entering patient information in their systems. TAMC Management needs to review these authorization failures more timely to ensure the data input accuracy and correct the 152 errors for social security number and date of birth

Modification Process To Revise Local Policies

The MSA and joint policies did not provide an effective policy modification process, which prevented timely reimbursement for care provided to VAPIHCS beneficiaries. The MSA outlines the process to modify existing joint policies. TAMC officials must

[7] LOC mismatch authorization errors occur when the sum of the individual duration of Levels of Care do not add up to the total stay.

submit, in writing and with an accompanying justification, all modification requests to the TAMC Joint Venture Office. TAMC personnel stated that the responsibility to maintain, update, and modify the MSA and joint policies, on behalf of TAMC, resides with the TAMC Joint Venture office. The Joint Venture Office Coordinator facilitates revisions on updates before presenting the requests to the Joint Business Working Group and to the Joint Venture Steering Group[8] for their approval. The modification becomes effective after the Joint Venture Steering Group approves and receives signatures from both agencies. However, when the two parties have not agreed, the results have been delays in modification, no changes at all, and sometimes, unfair financial advantage for VAPIHCS.

Disagreements between TAMC and VAPIHCS have prevented necessary modifications and changes to the reimbursement methodology and have contributed to $3.7 million in uncompensated care. An example of a repeatedly delayed and poorly negotiated policy at the center of disagreement between TAMC and VAPIHCS is the Joint Policy for Reimbursement. The Joint Policy for Reimbursement is to be updated annually between the two agencies and is intended for the purpose of tracing the financial obligations relating to the provision of patient care and other services exchanged between VAPIHCS and TAMC. Table 4 illustrates the delays in reimbursement methodology approval from the start of fiscal years.

Table 4. Delays in Reimbursement Methodology Approval

Fiscal Year	Date Approved	Days Since Start of FY (Oct 1)
FY 2009	February 20, 2009	142
FY 2010	December 15, 2009	75
FY 2011	June 21, 2011	263
FY 2012	December 27, 2011	87
FY 2013	Not Approved as of May 20, 2013	231

The delays are proving costly for TAMC. TAMC's Joint Venture Office Coordinator has recently attempted to revise portions of the policy for FY 2013 to remove what TAMC management felt were unfair financial benefits to VAPIHCS. Changes included revising the requirement to bill and not pay professional fees, establishing definitive policy regarding medical coding, and removing the Fee Based Claims System (FBCS) through which VAPIHCS is processing TAMC claims. Specifically:

[8] Both the Joint Business Working Group and Joint Venture Steering Group are composed of representatives from both TAMC and VAPIHCS management.

- **Professional Fees.** Beginning in FY 2010, the Reimbursement Methodology stated, "professional charges for attending and/or consulted physicians will be billed but not be required to be paid by VAPIHCS pending resolution between the TAMC Chief of Staff and the VAPIHCS Associate Director." TAMC Management was able to quantify for FY 2011 through FY 2013 the cost of professional charges at $3.7 million, while still awaiting resolution. For the Draft FY 2013 Reimbursement methodology, however, TAMC management revised the statement, removing the "not required to pay" portion.

- **Medical Coding Disagreements.** Many times, the Draft FY 2013 Reimbursement Methodology, identifies that DoD follows the Military Health System Guidelines for coding inpatient and outpatient care. Although not able to quantify how many claims have been denied by VAPIHCS because of medical coding disagreements, TAMC management expressed concernswith the differences in the coding methodologies that the joint partners use. Specifically, TAMC management shared a VAPIHCS report that stated a lack of confidence in TAMC's coding abilities and its reluctance to pay claims without prior review. Furthermore, the TAMC Joint Venture Coordinator stated that VAPIHCS management stated that TAMC was engaging in fraudulent billing practices.

  In response to VAPIHCS, TAMC requested that MEDCOM perform a coding review. The review found no patterns or trends to support fraudulent billing practices. Also, VAPIHCS did not use the Military Health System Coding guidelines as binding guidance for the review, which is stipulated in the sharing agreement.

- **Claims Subject to FBCS.** Within the Draft FY 2013 Reimbursement Methodology, TAMC management attempted to add a section stating, "for Joint Venture claims from TAMC, all claims will be processed and paid without being subject to FBCS edits. Reconciliation of claims and application of these audits will be performed post payment." TAMC personnel stated that FBCS is a new system through which VAPIHCS processes claims; however; FBCS was never approved within the Joint Venture. Although not able to quantify the dollar value of claims denied by VAPIHCS processing claims through FBCS, TAMC staff expressed numerous concerns with this system. These concerns included the numerous denials FBCS is producing because of VA processing errors and the waste of resources occurring when denials are printed and sent through the U.S. Postal Service instead of using

the E-DR contracted system. Figure 2 illustrates the denials that TAMC has received from FBCS at the time of our site visit on October 30, 2012, and a photo provided by TAMC personnel as of February 27, 2013 (estimated to now be more than 5,000).

Figure 2. FBCS Denials Mailings

The TAMC Joint Venture Office Coordinator stated that because of these proposed changes, among others, VAPIHCS will not sign the draft into current policy and the prior year (FY 2012) Joint Policy for Reimbursement remains in effect. As a result, the financial benefits of professional fees that are billed but not paid favor VAPIHCS and are at a cost to TAMC of about $3.7 million. In addition, VAPIHCS is inappropriately denying thousands of claims because of medical coding concerns and a new processing system. Because of the magnitude of problems identified in FY 2012 and FY 2013, TAMC management needs to immediately elevate to MEDCOM and Health Affairs a request to review this reimbursement policy regarding the additional financial benefits provided to VAPIHCS, coding disagreements, the use of FBCS in denying TAMC claims, and the delays in achieving approval by both parties.

Additional Management Oversight Is Needed

The MSA and Joint Policies for reimbursement, claims and payment and authorizations were ineffective to obtain timely reimbursement for services rendered to VAPIHCS beneficiaries. This occurred because the Commander at TAMC, Commander at MEDCOM, and Director of DVPCO did not provide adequate oversight to the Joint Venture relationship. Management at these levels had been aware of the many problems presented within this report and the rising delinquent debt since 2010 without adequately attempting to resolve the longstanding problems with VAPIHCS.

Oversight Was Insufficient by Prior TAMC Leadership

The prior Commanding General of TAMC was also the Commanding General of the PRMC. He oversaw operations at TAMC and PRMC from May 25, 2010, through October 3, 2012. During his tenure, both he and his staff were made aware of these longstanding problems. Also, they implemented inadequate policies, as well as had opportunities presented to them by staff to resolve these problems and potentially improve processes. As of October 1, 2012, TAMC management reported that VAPIHCS was delinquent by $26.2 million for services provided from FY 2009 through FY 2012. TAMC management has, without success, routinely tried to resolve these issues at the lowest levels to properly be reimbursed for services rendered.

Lack of an Operational Dispute Resolution Process at TAMC

The dispute resolution process is not working effectively for the Joint Venture. Joint Policy #08-16 lays out a seven-level dispute resolution process to be used to resolve claims when they are not paid or when there is a question about the payment amount. The policy requires that problems not resolved in a timely manner be elevated from TAMC management up to the Commander, MEDCOM, and Assistant Secretary of Defense (Health Affairs).

The inadequate oversight of the dispute resolution process at TAMC has allowed millions of dollars in claims to remain unresolved, despite years of promises by VAPIHCS personnel that the problems would be solved. Examples of the claims that remained in dispute include claims denied because of coding errors and claims being processed and denied within the FBCS system. The prior Commanding General at TAMC did not take timely action to elevate these concerns in accordance with local Joint Policy. After the prior commanding general's departure, TAMC and PRMC officially elevated these concerns to MEDCOM (see Appendixes B and C), despite years of communication regarding the delinquent debt. TAMC management must elevate concerns in a timelier manner in accordance with Joint Venture policies.

Missed Opportunity To Improve the Authorization Process

The authorization process under the interagency sharing agreement allowed VAPIHCS to manipulate TAMC reimbursements. This occurred because VAPIHCS maintained oversight of the E-DR contract, which allowed VAPIHCS the authority only to generate an authorization number for each episode of care. As a result of this situation, TAMC lacked the authority to obtain reimbursement from VAPIHCS when a VAPIHCS-approved authorization number remained untimely or absent. TAMC

management previously attempted to take appropriate action to bring the E-DR ARMS-Pro billing module in house by submitting a contract request. Bringing the E-DR ARMS-Pro billing module in house would have allowed TAMC to generate the necessary authorizations, along with providing oversight to a DoD process, while saving $126,400 annually.[9] The request was approved on behalf of the commanding general in FY 2012; however, the decision was never implemented. TAMC management was unable to explain why the contract request was never fulfilled. TAMC management must work withMEDCOM to obtain contract oversight over the ARMS-Pro billing system with E-DR, thus allowing TAMC the needed administrative privileges over a DoD process

U.S. Army MEDCOM Oversight by Prior Leadership

U.S. Army Medical Command serves as the Major Command for both the PRMC and TAMC, and level seven in the dispute resolution process. MEDCOM should have elevated these concerns to achieve resolution between TAMC and VAPIHCS.

U.S. Army Medical Command personnel have long been aware of the problems presented by TAMC. MEDCOM provided a timeline of its actions regarding the delinquent debt dating back to 2008, but those actions have not been sufficient to resolve the problems. When we addressed these concerns to the Chief of Staff at MEDCOM, he stated that he should have done more to intervene and resolve these problems. During the course of our review, the Chief of Staff took official action in December 2012 to send a memo to the Assistant Secretary of Defense (Health Affairs) requesting assistance with the VAPIHCS billing problems. (See Appendix D.) On March 15, 2013, MEDCOM stated that VA had paid down the delinquent debt to $13.3 million.

Although these are steps in the right direction, MEDCOM did not take appropriate actions to assist in a timely manner and must continue elevating these concerns until all delinquent debt, unbilled claims, uncompensated care, and denial issues are resolved.

TRICARE Management Activity Oversight

One of the objectives of the DVPCO is to serve as the central entity within Health Affairs/ TRICARE Management Activity to monitor all VA/DoD Health Care Resource Sharing activities, to include Financial Management and Joint Ventures. The DVPCO provides administrative and operational support to the Health Executive Council, which is

[9] The TAMC Uniform Billing Office identified a contract savings of $126,400 by streamlining its ARMS-Pro billing services with existing services already provided to Korea and Japan.

composed of senior officials (to include Assistant Secretary of Defense [Health Affairs], Surgeon General of the Army, and Deputy Assistant Secretary of Defense [Health Budgets and Financial Policy]), whose responsibilities include overseeing working groups and identifying opportunities to enhance mutually beneficial coordination.

The Health Executive Council oversees the Financial Management Working Group, whose responsibilities include reviewing reimbursement policies and identifying policies requiring modification and clarification, developing recommendations for improving financial processes and practices, and resolving billing and reimbursement problems.

The Director of DVPCO referred to these problems as "local Army problems" that his office will not resolve because these problems are not seen as systemic across all Joint Ventures. He also stated that his office has been aware of the problems at TAMC for quite some time, but because no one has "formally" requested the office's assistance, his office has not intervened. The current billing and reimbursement problems date back to 2008. For years, TAMC management has been requesting help from MEDCOM and DVPCO. TAMC staff provided documentation showing it has attempted to elevate the billing problems to DVPCO starting in 2010. There is no requirement for a "formal" request to be a prerequisite of DVPCO involvement when the two agencies cannot agree. DVPCO management consistently maintained that these are local problems and refused to engage, despite billing and reimbursement problems being a responsibility of the Health Executive Council Financial Management Working Group. This is an example of the need for proactive management by DVPCO. DVPCO should present billing and reimbursement problems to the Health Executive Council Financial Management Working Group for resolution and develop and action plan to improve timely reimbursements for TAMC.

The Director DVPCO … stated that his office has been aware of the issues at TAMC for quite some time, but because no one has "formally" requested the office's assistance, his office has not intervened.

Impact of Insufficient Oversight

With the lack of sufficient oversight from the former TAMC Commander, Chief of Staff MEDCOM, and Director DVPCO, the burden of about $26.2 million in delinquent debt, $3.7 million in unbilled claims, and $3.7 million in uncompensated care will continue to grow. Furthermore, the policies governing the Joint Venture and the delinquent debt have not ensured that the military treatment facility can meet the

reimbursement requirement of Section 8111, Title 38, United States Code, which states that an agency will be reimbursed for the cost of health care resources provided. TAMC needs to initiate action to submit the $3.7 million in unbilled claims, $3.7 million in billed professional fees, and $56,267 in deleted authorization claims. MEDCOM and the DVPCO must take immediate action to resolve the longstanding issue of TAMC not being reimbursed for the medical care provided to VAPIHCS beneficiaries.

Management Comments on the Finding and Our Response

Management Comments

The Assistant Secretary of Defense (Health Affairs) generally concurred with the report's findings and conclusions. However, he submitted general comments stating that it was unclear how the delinquent debt will continue to grow because VA has reduced the debt by 50 percent during the course of the audit. Additional comments also included the DVPCO did identify and work within its means to identify resolutions for TAMC reimbursement issues by identifying improvements in the Consolidated DSS Final Report dated July 2008, which was provided to the Health Executive Council. He also stated that the Health Executive Council is separate and above the DVPCO, which provides administrative and operational support to the Health Executive Council. And finally, the Assistant Secretary of Defense (Health Affairs) stated that the DVPCO has limited authority to involve itself in the operational issues occurring at the unit level to resolve the reimbursement issues at TAMC.

Our Response

We considered the Assistant Secretary of Defense (Health Affairs) general comments to the final report. We did revise the statement within the report to note the DVPCO provides administrative and operational support to the Health Executive Council. With regards to his other general comments, the following are our comments. Although VA has paid down debt, the paying down of debt does not mean that the weaknesses that contributed to the debt, from both DoD and VA, have been resolved. Implementation of the recommendations made to TAMC and MEDCOM will help resolve some of these concerns; however department level assistance will be required to resolve the longstanding problems between TAMC and VAPIHCS.

The Consolidated DSS report in reference is from July 2008, before the implementation of E-DR. A subsequent solution was developed through the use of E-DR; however, issues identified within this report stem from the system and contract. Furthermore, the rising delinquent debt reviewed in the report was from 2009 through 2012 and does not support improvements made to the revenue cycle process between the joint venture partners since 2008.

Finally, we agree with the importance of the military chain of command; however, neither MEDCOM nor TAMC have authority over VAPIHCS. When joint venture partners reach impassable roadblocks, the issues need to be elevated to the DVPCO for assistance, and possibly presented to the Financial Management Working Group. MEDCOM provided evidence to show attempts to get assistance from the DVPCO, with no resolution/assistance provided as such issues continue to be problematic, and delinquent debt continues to rise.

Recommendations, Management Comments, and Our Response

Redirected Recommendation

As a result of management comments, we redirected Recommendation 3 to the Assistant Secretary of Defense (Health Affairs) which has the authority to implement the recommendation.

1. We recommend the Commander, Tripler Army Medical Center:

a. Request the required waiver from the Office of the Under Secretary of Defense in accordance with DoD Financial Management Regulation volume 4, chapter 3.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating the waiver will request permission for TAMC to continue to provide services to VA beneficiaries even through reimbursements continue to be in arrears. Submission of the waiver will commence August 1, 2013.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. Command did provide a copy of the waiver request, initially submitted on May 1, 2013. No further comments are required.

b. Review, research, and correct the unbilled claims containing billing and coding errors and claims containing authorization errors to comply with DoD Financial Management Regulation volume 4, chapter 3, by recording the unbilled claims as receivables.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that TAMC's Uniform Business Office is identifying billing discrepancies, correcting computer logic, and reprocessing claims of all prior years. Currently, the focus is on FY 13 claims. Staffing shortages and furlough will significantly impact the timeline for both the Joint Venture Office and Uniform Business Office. Review and correction of FY 13 bills should be complete by December 31, 2013, and the remainder by September 30, 2014.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

c. Revise the Joint Policy #08-016 for Claims and Payment to comply with DoD Financial Management Regulation volume 4, chapter 3.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that on July 10, 2013, the Joint Business Working Group discussed Joint Policy #08-016 for Claims and Payment and agreed on the importance of updating the policy. TAMC will request assistance and guidance from MEDCOM if problems are encountered during the update process. A draft policy is anticipated to be submitted to the Joint Venture Steering Group on August 20, 2013, and a final version will be sent to MEDCOM by September 30, 2013.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. Command stated the Coding and Billing subgroup requested an extension to present the draft policy, which was granted. Therefore, it will be presented at the next monthly meeting. No further comments are required.

d. Establish written procedures on roles and responsibilities for staff to research, review, and correct claims containing errors.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that TAMC will develop staff roles and responsibilities related to the revenue cycle, including VA Referral center contact representatives/utilization management registered nurses (authorization/consult approval); clinical frontline medical service assistants; coders; and Uniform Billing Office and Accounts Receivable staff. This information will be included in a Standard Operating Procedure to be presented to the TAMC Center Joint Venture working team for approval on October 7, 2013. Additionally, TAMC instituted quarterly training on how to identify dual-eligible patients and a VA referral, as well as tips for booking the beneficiaries and entering the authorization.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

e. Update the Joint Policy #08-020 for Authorization to:

(1) Grant administrative privileges within Enhanced-Document and Referral Management System to Tripler Army Medical Center management to generate, adjust, or amend an authorization.

(2) Allow Tripler Army Medical Center the ability to properly bill Veterans Affairs Pacific Islands Health Care System for services rendered to its beneficiaries, regardless of whether Veterans Affairs Pacific Islands Health Care System provides an authorization.

(3) Standardize a shared methodology when calculating inpatient Level of Care days under the interagency sharing agreement.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, disagreed, stating that TAMC is unable to grant administrative privileges within the E-DR because that function is controlled by VAPIHCS. TAMC will request VAPIHCS to grant administrative privileges to TAMC management personnel, but cannot ensure agreement from VAPIHCS. The request will be made during an August 2013 Joint Business Working Group meeting.

In addition, it is inconsistent with regulatory guidance to allow TAMC to bill VAPIHCS for services rendered without proper authorization. Army Regulation 40-400, paragraph 3-23a(2) states that Army Military Treatment Facilities will furnish medical care to a veteran on the basis of an authorization for treatment from the field station having jurisdiction. Reimbursement will not be made by the VA for medical care furnished before the effective date of the authorization, except in emergency medical care.

Finally, the shared methodology for calculating inpatient LOC days has been implemented. The contractor indicated that the most current business rules are loaded in the VA Authorization Check Web Service, which pulls data from the Referral Management Inpatient Module of E-DR and performs the LOC duration calculations.

Our Response

Comments from the Chief of Staff, MEDCOM, were partially responsive. If VAPIHCS refuses to grant administrative privilege, TAMC's ability to properly bill VAPIHCS can be achieved only from actions taken from MEDCOM's response to Recommendation 2.b. Therefore if actions taken in Recommendation 2.b are implemented, this needs no further action.

Based on Army Regulation 40-400, TAMC has the ability to (1) deny services to VAPIHCS beneficiaries when an authorization for such care has not been received, or (2) collect locally from the veteran concerned. TAMC officials stated that the political fallout associated with denying services or locally billing VAPIHCS beneficiaries did not serve in the best interest of the sharing agreement. We agreed with this logic and believe these expectations were overstated and not viable options that served in the best interest of the sharing agreement. The goal is to improve access, quality, efficiency, and effectiveness of health care provided by the Military Health System and Veterans Health Administration to their respective beneficiaries as outlined in DoD Instruction 6010.23, "DoD and Department of Veteran Affairs (VA) Health Care Resource Sharing Program,"

dated January 23, 2012. Therefore, we ask the Chief of Staff, MEDCOM, to provide further detail in response to the final report, on how to improve the authorization process between VAPIHCS and TAMC by October 18, 2013.

Comments from the Chief of Staff, MEDCOM, were responsive regarding LOC days under the sharing agreement. No further comments are required.

f. Reinstate the deleted claims and process the claims to Veterans Affairs Pacific Islands Health Care System for reimbursement of services rendered.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that the Joint Venture Office requested a list from the billing contractor and will review the list of claims deleted for straight K61 beneficiaries (straight K61 beneficiaries are VA beneficiaries) and reprocess valid claims. VAPIHCS indicated that it will not process any retrospective authorizations for any period of time until it receives guidance from the Veterans Integrated Service Network. TAMC will request assistance and guidance from MEDCOM, if necessary, but anticipates action will be complete by December 31, 2013.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

g. Review authorization failures more timely to ensure "Internal Entry Number" is properly linked to the appropriate appointment and the accuracy of data input. Claims containing authorization errors need to be resolved and processed.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that TAMC is reviewing options to address this recommendation, including hiring additional staff or making changes to E-DR to automate linkage of authorizations to the internal entry number to address this issue. Because of sequestration, we anticipate action will be complete by December 31, 2014.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

h. Elevate to U.S. Army Medical Command a request to review the reimbursement policy regarding the additional financial benefits provided to Veterans Affairs Pacific Islands Health Care System, coding disagreements, the use of Fee Based Claims System in denying Tripler Army Medical Center claims, and the delays in achieving approval by both parties. Additionally, Tripler Army Medical Center must elevate all unresolved recommendations (1.a to 1.h) in a timely manner to the U.S. Army Medical Command if Tripler Army Medical Center and Veterans Affairs Pacific Islands Health Care System management fail to achieve a negotiated solution.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, TAMC, agreed, stating that TAMC will elevate to MEDCOM requests to review the reimbursement policy regarding additional financial benefits and unresolved recommendations in a timely manner. He also stated VAPIHCS controls the Fee Based Claims System and informed TAMC that VA Central Office denied a request to bypass the system for Joint Venture claims. TAMC will elevate this issue to MEDCOM. These actions will be completed by December 31, 2013.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

2. We recommend that the Commander, U.S. Army Medical Command

a. Elevate to DoD/Veterans Affairs Program Coordination Office a request to review the reimbursement policy regarding the additional financial benefits provided to Veterans Affairs Pacific Islands Health Care System, coding disagreements, the use of Fee Based Claims System in denying Tripler Army Medical Center claims, and the delays in achieving approval by both parties.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, MEDCOM, agreed, stating that as a follow up to the December 17, 2012, memorandum to the Assistant Secretary of Defense (Health Affairs), MEDCOM will request further assistance from Assistant Secretary of Defense (Health Affairs) to resolve the remaining TAMC-VAPIHCS billing issues. Numerous meetings did occur between January and March 2013, and although some progress occurred, Department-level assistance is still required and will be requested by August 31, 2013.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

b. Direct Tripler Army Medical Center obtain contract oversight over the Accounts Receivable Management System-Professional billing system with Enhanced-Document and Referral Management System. This authority would allow Tripler Army Medical Center the needed administrative privileges over a DoD process.

Management Comments

The Chief of Staff, MEDCOM, responding for the Commander, MEDCOM, disagreed, stating that TAMC cannot unilaterally obtain oversight for the current contract without obtaining consent from VAPICHS. However, MEDCOM will direct TAMC to officially request administrative privileges for the ARMS-Pro and E-DR.

He further stated that if the VAPIHCS will not allow access, MEDCOM will direct U.S. Army Pacific Regional Medical Command to execute a contract line item number under the current contract for ARMS-Pro used in Korea and Japan. Executing the contract line item number will enable TAMC to recognize receivables when corresponding revenue is earned in accordance with DoD FMR, Volume 4, chapter 3. Additionally, executing the contract line item number will be an interim solution until deployment of the Armed Forces Billing and Collection Utilization Solution. Once deployed, the Armed Forces Billing and Collection Utilization Solution will be the Army's billing platform, and TAMC will be required to use the Armed Forces Billing and Collection Utilization Solution billing process. Full deployment of the Armed Forces Billing and Collection Utilization Solution is expected by December 31, 2014.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. Although the Chief of Staff, MEDCOM, did not agree with the recommendation, the actions to be taken would be sufficient to meet the intent of the recommendation. Therefore, no further comments are required.

3. We recommend that the Assistant Secretary of Defense (Health Affairs) require the Director DoD/Veterans Affairs Program Coordination Office, present these billing and reimbursement problems to the Financial Management Working Group, which reports to the Health Executive Council, for resolution and develop an action plan to improve reimbursements.

Management Comments

The Assistant Secretary of Defense (Health Affairs) partially agreed with Recommendation 3. He stated that the Director, TRICARE Management Activity, whom the recommendation was originally directed to, is dual-hatted as the Assistant Secretary of Defense (Health Affairs), and as such is the DoD Co-Chair of the Health Executive Council. Therefore, the recommendation should be directed to the Assistant Secretary of Defense (Health Affairs). The Financial Management Working Group reports to the Health Executive Council, not the DVPCO. He recommended rewording the recommendation.

Our Response

We consider the Assistant Secretary of Defense (Health Affairs) comments partially responsive. We have revised the recommendation to incorporate the suggested redirection; however, comments did not address how to ensure that the appropriate offices are brought together to assist the Financial Management Working Group, when these meetings would occur, or the subsequent action plan to improve reimbursements. Therefore, we ask the Assistant Secretary of Defense (Health Affairs) to provide further detail in response to the final report by October 18, 2013.

Management Comments on the Potential Monetary Benefits and Our Response

Management Comments

The Chief of Staff, MEDCOM, agreed with the potential monetary benefits, stating actual monetary benefits will be confirmed during the follow up process to ensure that the recommendations were effectively implemented.

Our Response

Comments from the Chief of Staff, MEDCOM, were responsive. No further comments are required.

Management Comments on Internal Control Weaknesses

The Chief of Staff, MEDCOM, acknowledged our identification of internal control weaknesses and the intent to provide a copy of the report to the senior official responsible for internal controls in Department of Army. Actions taken in response to the recommendations should correct these weaknesses.

Appendix A

Scope and Methodology

We conducted this performance audit from July 2012 through September 2013 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.

We interviewed personnel from TAMC, VAPIHCS, MEDCOM, and DVPCO through both site visits and teleconferences to obtain information and source documentation on health care services provided by TAMC to VAPIHCS beneficiaries. During the site visits to TAMC and MEDCOM, we observed daily procedures performed by personnel and examined key documents related to audit objectives. We also reviewed and analyzed claims data in the ARMS-Pro computer system.

We obtained, reviewed, and analyzed Federal, DoD, Army, and local regulations, instructions, and guidance related to health care services between VA and DoD. We focused our review on the Joint Policy for Authorizations (signed March 2008), the Joint Policy for Claims and Payment (signed March 2008), and the FY 2012 Reimbursement Methodology (signed December 2011). We compared actions being performed by personnel at TAMC, VAPIHCS, MEDCOM, and DVPCO to what the Federal, DoD, Army, and local regulations, instructions, and guidance requires.

Our review was only of the DoD involvement with the authorization and claims process for the Joint Venture between FY 2009 and FY 2012 for TAMC and VAPIHCS. We chose to start our review with FY 2009 claims because FY 2009 coincided with the implementation of E-DR. We nonstatistically selected for review 50 authorizations to understand the authorization process, along with compliance with Joint Policy authorization guidelines, and 60 claims to understand the claims and payment process, along with compliance with the DoD FMR volume 4, chapter 3, and local Joint Policy. In selecting the authorizations and claims, we reviewed the higher dollar items from each category. We derived all sampled claims from the E-DR ARMS-Pro billing system.

We selected the 50 authorizations from a universe of 8,745 authorizations valued at $20.9 million, which represented both inpatient and outpatient authorizations from data provided as of October 11, 2012. Of the 50 authorizations, we

reviewed 17 inpatient authorizations valued at $1,070,667, from the 905 inpatient authorizations; and 33 outpatient authorizations valued at $177,322, from the 7,840 outpatient authorizations. Table 5 identifies the authorizations and the universe from which they were selected.

Table 5. Authorizations Selected for Review

Type	Authorizations Reviewed	Amount Reviewed	Total Authorizations	Total Amount
Inpatient Authorizations	17	$1,070,667	905	$15,267,934
Outpatient Authorizations	33	177,322	7,840	5,665,037
Total Authorizations	50	$1,247,989	8,745	$20,932,971

We reviewed FY 2012 information in the E-DR ARMS-Pro billing systems and identified 11,034 claims, valued at $3.45 million, not reimbursed because they remained unauthorized by VAPIHCS. With TAMC and contractor personnel support, we were able to identify the reason why each claim remained unauthorized, based on coded data in the E-DR ARMS-Pro billing system; we used the coded data as the basis of the authorization discussion in the report.

The 60 claims selected for review from data provided as of October 11, 2012, were valued at $2.5 million. Of the 60 claims, we reviewed 30 from the unbilled category that TAMC management identified as claims not yet recorded as accounts receivable. We reviewed 15 claims valued at $103,718, from the 3,917 claims identified as unbilled, containing billing or coding errors; in addition, we reviewed 15 claims valued at $922,677 from 11,034 claims identified as unbilled unauthorized. We selected another 15 claims valued at $575,336 from the 5,935 claims identified as fully paid. Finally, we selected 15 claims valued at $953,995 from the 26,606 claims identified as unprocessed (and therefore unpaid). Table 6 identifies the claims reviewed and the universe from which they were selected.

Table 6. Claims Selected for Review

Type	Claims Reviewed	Amount Reviewed	Total Claims	Total Amount
Unbilled – billing and coding errors	15	$103,718	3,197	$242,475
Unbilled – unauthorized	15	922,677	11,034	3,449,918
Fully Paid	15	575,336	5,935	3,706,758
Unprocessed	15	953,995	26,606	12,578,056

We also reviewed 10 denial letters from the FBCS system. Because FBCS was not an approved Joint Venture system, these letters and subsequent denials do not appear in the E-DR ARMS-Pro system. Accordingly, these denials were mailed to TAMC, not transmitted electronically, and therefore these denials were not available for review from the E-DR ARMS-Pro system. We reviewed these letters to identify the FBCS denial code along with validate TAMC management concerns regarding claims being denied outside the span of control of TAMC.

We did not assess overall contractor performance with the E-DR ARMS-Pro billing system because the contract is a VA contract. Additionally, recommendations cannot be made outside the Department of Defense. We referred to the VA OIG any VA processes or actions that we observed that may be contributing to the rising delinquent debt and ineffectiveness of the policies. We requested assistance from VA OIG to help with the audit or possibly perform a joint audit early in the audit; however, VA OIG personnel stated that other projects would take precedent and could not provide assistance in the matter at that time.

Use of Computer-Processed Data

We relied on computer-processed data to support our findings and conclusions. Specifically, we relied on management reports generated from the E-DR ARMS-Pro billing system to select the authorization and claims samples used to complete this audit.

To assess the reliability of this data, we reviewed source documentation related to the transactions, obtained information from TAMC management and contractor support regarding system processes, and reviewed various system reports. Based on this information, we determined that the data were sufficiently reliable for the purposes of this report.

Use of Technical Assistance

The Quantitative Methods Division reviewed audit documents and advised us on the validity of the nonstatistical sample selected. Also, the Quantitative Methods Division reviewed Appendix A: Scope and Methodology, for technical clarity and defensibility.

Prior Coverage

During the last 5 years, the Government Accountability Office (GAO) and the Department of Veterans Affairs Office of the Inspector General (VA OIG) have issued three reports discussing topics related to VA and DoD's Joint Venture for health care services. Unrestricted GAO reports can be accessed over the Internet at http://www.gao.gov. Unrestricted VA OIG reports can be accessed at http://www.va.gov/oig/publications/default.asp.

GAO

Report No. GAO-12-992, "VA and DoD Health Care: Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities," September 2012

Report No. GAO-08-399, "VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed," March 2008

VA OIG

Report No. 09-01643-170, "Combined Assessment Program Review of the VA Pacific Islands Health Care System Honolulu, Hawaii," July 29, 2009

Appendix B

Tripler Army Medical Center Memo to Pacific Regional Medical Command Requesting Assistance

DEPARTMENT OF THE ARMY
HEADQUARTERS, TRIPLER ARMY MEDICAL CENTER
1 JARRETT WHITE ROAD
TRIPLER AMC, HAWAII 96859-5000

REPLY TO
ATTENTION OF

MCHK-DCA

04 October 2012

MEMORANDUM FOR Commander, Pacific Regional Medical Command, Tripler Army Medical Center, 1 Jarrett White Road, Honolulu, HI 96859-5000

SUBJECT: Request for Assistance in Resolving Outstanding VA Indebtedness

1. Request your assistance in the collection of debts owed to Tripler Army Medical Center (TAMC) by the Veterans Affairs Pacific Island Health Care System (VAPHICS).

2. Over the past four fiscal years beginning in FY09, debts owed to TAMC for the provision of medical services to Veterans Affairs beneficiaries have increasingly grown until now the amount owed by VAPHICS to TAMC is $24,681,388.05. This growth in indebtedness has occurred in spite of our best efforts, and repeated promises by VAPHICS to pay this indebtedness. Enclosed is the summary of amounts owed by fiscal year.

3. The point of contact for this action is the Chief of Patient Administration [redacted].

Encl

HUGH A. MCLEAN JR.
LTC, MS
Deputy Commander for Administration

Appendix C

Pacific Regional Medical Command Memo to U.S. Army Medical Command Requesting Assistance

DEPARTMENT OF THE ARMY
PACIFIC REGIONAL MEDICAL COMMAND (PRMC)
1 JARRETT WHITE ROAD
TRIPLER AMC, HAWAII 96859-5000

MCHK-CG 04 October 2012

MEMORANDUM FOR LTG Patricia D. Horoho, Commander, MEDCOM, 1 Leesburg Pike, Suite 672, Falls Church, VA 22041

SUBJECT: Request for Assistance in Resolving Outstanding VA Indebtedness

1. I respectfully request your assistance in the collection of debts owed to Tripler Army Medical Center (TAMC) by the Veterans Affairs Pacific Island Health Care System (VAPHICS).

2. Over the past four fiscal years beginning in FY09, debts owed to TAMC for the provision of medical services to Veterans Affairs beneficiaries have increasingly grown; the current amount owed by VAPHICS to TAMC is $24,681,388.05. This growth in indebtedness has occurred in spite of our best efforts, and repeated promises by VAPHICS to pay this indebtedness. Enclosed is the summary of amounts owed by fiscal year.

3. The point of contact for this action is the Deputy Commander for Administration, [redacted]

J. ANSON SMITH
Colonel, USA
Commanding

Appendix D

U.S. Army Medical Command Memo to Assistant Secretary of Defense (Health Affairs) Requesting Assistance

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

REPLY TO
ATTENTION OF

DASG-CS

17 DEC 2012

MEMORANDUM FOR Assistant Secretary of Defense (Health Affairs), ATTN: COL Laura Breen

SUBJECT: Request for Assistance

1. Request assistance from the Department of Defense (DoD) to achieve resolution of an intractable billing issue with the Department of Veterans Affairs (VA).

2. The Tripler Army Medical Center (TAMC) has been in a joint venture partnership with the VA Pacific Islands Healthcare System since 1991. We are proud to say that over this period TAMC has provided world-class healthcare to countless VA beneficiaries. While the provision of these services to VA beneficiaries is recognized as very beneficial, timely reimbursement from the VA has hit many roadblocks. As noted in the September 2012 GAO Report, asymmetrical business process has lead to a VA indebtedness to TAMC for $26M from FY 2009 to 2012 (FY09-$1.2M; FY10-$4.7M; FY11-$9.2M; FY12-$11.8M).

3. After extensive efforts over several years, neither TAMC nor MEDCOM has been able to resolve these business process issues. In September of 2011 our staff assembled a team of accounting, business process, and coding subject matter experts (SMEs) to address the issues. The team worked with the VA Central Office and VA/DoD Programs SMEs for over 16 months without resolution, as recently noted by the DoD Inspector General.

4. We all want this large and important joint venture to be successful and we need DoD engagement to help us attain a definitive and lasting solution to these business process issues with the VA.

5. My point of contact for this request is [redacted], TRICARE Division, Health Care Delivery, MEDCOM, G-3/5/7, [redacted] or email [redacted]

FOR THE COMMANDER:

Herbert A Coley
HERBERT A. COLEY
Chief of Staff

Appendix E

Summary of Potential Monetary Benefits

Recommendation	Type of Benefit*	Amount of Benefit	Account
3	Economy and Efficiency. VAPIHCS reimbursement for healthcare services rendered by TAMC to VAPIHCS patients.	Total benefit, $33.6 million. ($13.4 million was paid during the course of the audit.[10] An additional $13.3 million in delinquent debt, $3.7 million in unbilled claim, and $3.7 million in uncompensated care must still be reimbursed by VAPIHCS.)	97 0130 1881 (DHP O&M)

*Note: Potential monetary benefits are funds put to better use or questioned costs.

[10] On March 15, 2013, U.S. Army Medical Command provided documentation showing the delinquent debt had risen to $26.7 million; VA paid $13.4 million toward the debt, reducing the amount owed to $13.3 million. Therefore, the debt rose from the $26.2 million as of October 1, 2012, to $26.7 million. The total benefit calculation is derived from the $26.2 million delinquent debt during our review, $3.7 million in unbilled claims, and $3.7 million in uncompensated care.

Management Comments

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 06 2013

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
PRINCIPAL ASSISTANT INSPECTOR GENERAL FOR AUDITING

SUBJECT: Response to Inspector General Draft Report D2012-D000DA-0190.000 – "Audit of the Interagency Agreement for Medical Services Between Tripler Army Medical Center and the Department of Veterans Affairs"

Thank you for the opportunity to review and provide comments on the Department of Defense (DoD) Inspector General Draft Report on Project No. D2012-D000DA-0190.000, "The Department of Defense and Veteran Affairs Health Care Joint Venture at Tripler Army Medical Center Needs More Management Oversight." This memorandum constitutes DoD, Office of the Assistant Secretary of Defense (Health Affairs') response to the subject report. I generally concur with the report's findings and conclusions with the exception of Recommendation 3, for which I partially concur. My specific comments on the draft report are included in the attached Response to Recommendations.

Please feel free to direct any questions on this subject to my points of contact, [redacted] may be reached at [redacted] may be reached at [redacted]

Jonathan Woodson, M.D.

Attachments:
As stated

Assistant Secretary of Defense (Health Affairs) Comments (cont'd)

Final Report Reference

DEPARTMENT OF DEFENSE INPSECTOR GENERAL
DRAFT REPORT ON PROJECT NO. D2012-D000DA-0190.000 -
"TRIPLER ARMY MEDICAL CENTER HEALTH CARE PAYMENT PROCESS NEEDS IMPROVEMENT"

RESPONSE TO RECOMMENDATIONS

Revised/Redirected

RECOMMENDATION 3: We recommend that the Director, TRICARE Management Activity (TMA) require the Director, DoD Veterans Affairs Program Coordination Office, present these billing and reimbursement problems to the Health Executive Committee (HEC) Financial Management Working Group for resolution and develop an action plan to improve reimbursements.

DoD RESPONSE: Partially concur with the recommendation. The Director, TMA, is dual-hatted as the Assistant Secretary of Defense (Health Affairs), and as such is the DoD Co-Chair of the HEC. The Financial Management Working Group reports to the HEC, not the DoD/VA Program Coordination Office. Recommend rewording as follows:

"We recommend that The Assistant Secretary of Defense (Health Affairs) ensure that the appropriate offices involved in this project are brought together to assist the FMWG in developing a plan to correct procedures and improve reimbursements."

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Assistant Secretary of Defense (Health Affairs) Comments (cont'd)

DEPARTMENT OF DEFENSE INPSECTOR GENERAL
DRAFT REPORT ON PROJECT NO. D2012-D000DA-0190.000 -
"TRIPLER ARMY MEDICAL CENTER HEALTH CARE PAYMENT PROCESS NEEDS IMPROVEMENT"

OVERALL COMMENTS

COMMENT 1: "Furthermore, without a mutual solution between the Department of Defense and Department of Veterans Affairs (VA) to address the longstanding problems, the burden of about $27.2 million in delinquent debt, $3.7 million in unbilled claims, and $3.7 million in uncompensated care will continue to grow." (page. i)

"…MEDCOM stated that VA had paid down the delinquent debt to $13.3 million as of March 15, 2013." (page 4)

RESPONSE 1: These findings seem to contradict one another without additional context. VA appears to have decreased the outstanding debt by 50 percent, so it is unclear how the debt is expected to grow.

COMMENT 2: "Commander TAMC, Commander U.S. Army Medical Command (MEDCOM), and Director DVPCO did not comply with regulations and policies to obtain timely reimbursement for health care services provided to VAPIHCS beneficiaries." (page 3)

RESPONSE 2: DoD/VA Program Coordination Office (DVPCO) did identify and work within its means to identify resolution for the Tripler Army Medical Center (TAMC) health care service reimbursement issues.

Identification and summary of an inadequate claims, billing, and reimbursement process between TAMC and VA Pacific Island Health Care System (VAPIHCS) was raised and articulated during Hawaii's participation in the FY 2003 National Defense Authorization Act, Section 722, 5-year Demonstration Site Support (DSS) program, operated by DVPCO. DSS focused on three areas: 1) Budget and Financial Management; 2) Coordinated Staffing and Assignment; and 3) Medical Information and Information Technology. TAMC and VAPIHCS participation in the demonstration program was to find a solution to their manual and untimely claims, billing, and reimbursement issues. The subsequent solution was developed through the use of the enhanced Document and Referral Management tool. Details of Hawaii's revenue cycle process improvements are found in the Consolidated DSS Final Report dated July 2008[1]. DVPCO created the report with agreed upon recommendations for improvement. DVPCO also provided the Final Report to the HEC, which approved it October 2008. A copy was also furnished to the GAO in May 2009.

[1] The Consolidated DSS Final Report can be found here: http://www.tricare.mil/DVPCO/joint-init.cfm

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Assistant Secretary of Defense (Health Affairs) Comments (cont'd)

Final Report Reference

COMMENT 3: "Within the DVPCO resides the Health Executive Council…" (page 18)

Revised

RESPONSE 3: The Health Executive Committee is co-chaired by the Assistant Secretary of Defense (Health Affairs) and the VA Under Secretary for Health. It is separate and above DVPCO. One of the core functions of the DVPCO is to provide administrative support to the HEC.

COMMENT 4: "The Director DVPCO referred to these problems as "local Army problems" that his office will not resolve because these problems are not seen as systemic across all Joint Ventures. He also stated that his office has been aware of the problems at TAMC for quite some time, but because no one has "formally" requested the office's assistance, his office has not intervened. The current billing and reimbursement problems date back to 2008. For years, TAMC management has been requesting help from MEDCOM and DVPCO. TAMC staff provided documentation showing it has attempted to elevate the billing problems to DVPCO starting in 2010. There is no requirement for a "formal" request to be a prerequisite of DVPCO involvement when the two agencies cannot agree. DVPCO management consistently maintained that these are local issues and refused to engage, despite billing and reimbursement problems being a responsibility of the Health Executive Council Financial Management Working Group." (pages 18-19)

RESPONSE 4: As the DoD IG Report correctly concludes, there are eight specific actions for TAMC leadership and an additional two recommendations for Army MEDCOM. These recommendations reflect the accurate spirit of the Director, DVPCO's comments. TAMC is an operational unit of Army MEDCOM and is under the jurisdiction of the Army. While this does not absolve DVPCO of its responsibility to provide oversight, it does limit the authority with which DVPCO can involve itself in the operational issues occurring at the unit level as detailed in the IG report. The VA/DoD Health Care Resources Sharing Guidelines Memorandum of Understanding and DoD Instruction 6010.23 stress the importance of the role of the Military Department chain-of-command, which is also consistent with Title 38, United States Code, Section 8111.

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U.S. Army Medical Command Comments

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042-5140

REPLY TO ATTENTION OF

DASG-ZA

21 AUG 2013

MEMORANDUM FOR Department of Defense Inspector General, 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: Reply to Draft Audit Report The Department of Defense and Veteran Affairs Health Care Joint Venture at Tripler Army Medical Center Needs More Management Oversight (Project No. D2012-D000DA-0190.000)

1. Thank for you the opportunity to provide comments on the subject report. Our comments are enclosed for your consideration.

2. Our point of contact is [redacted].

FOR THE SURGEON GENERAL:

ULDRIC L. FIORE, JR.
Chief of Staff

Encl

U.S. Army Medical Command Comments (cont'd)

U.S. Army Medical Command (MEDCOM) and
Office of the Surgeon General (OTSG)

Comments on DODIG Draft Report
DOD and VA Health Care Joint Venture at Tripler Army Medical Center
Needs More Management Oversight
(Project No. D2012-D000DA-0190)

DODIG recommended the Commander, Tripler Army Medical Center:

RECOMMENDATION 1.a.: Request the required waiver from the Office of the Under Secretary of Defense in accordance with DoD Financial Management Regulation volume 4, chapter 3.

RESPONSE: Concur. The waiver memorandum will include a request to permit Tripler Army Medical Center (TAMC) to continue to provide services to VA beneficiaries even though Veterans Affairs Pacific Islands Health Care System (VAPIHCS) reimbursements continue to be in arrears.

The monthly memorandum will continue to be submitted until VAPIHCS is in compliance with the DoD Financial Management Regulation, Volume 4, chapter 3, which states that DoD activities will not perform reimbursable work for another Federal Agency that is 90 days or more in arrears in payment.

Submission of waiver memorandums will commence 1 August 2013.

RECOMMENDATION 1.b.: Review, research, and correct the unbilled claims containing billing and coding errors and claims containing authorization errors to comply with DoD Financial Management Regulation volume 4, chapter 3, by recording the unbilled claims as receivables.

RESPONSE: Concur. TAMC's Uniform Billing Office is identifying billing discrepancies, correcting computer logic, and reprocessing claims of all prior years. Currently, the focus is on FY 13 claims.

The Joint Venture Office reviewed FY 13 authorization errors and identified about 300 inpatient episodes to the billing contractor with authorization numbers for reprocessing. In addition, the Joint Venture Office is entering authorizations for about 1,450 outpatient and 2,200 ancillary FY 13 claims (October through April), and marking them for reprocessing. Once the claims are clear and non-billable encounters are extracted, the remaining FY 13 claims will be reviewed.

Encl

U.S. Army Medical Command Comments (cont'd)

Staffing shortages and furlough will significantly impact the timeline for both the Joint Venture Office and the Uniform Business Office. Review and correction of FY 13 bills should be complete by 31 December 2014, and the remainder by 30 September 2014.

RECOMMENDATION 1.c.: Revise the Joint Policy #08-016 for Claims and Payment to comply with DoD Financial Management Regulation volume 4, chapter 3.

RESPONSE: Concur. On 10 July 2013, the Joint Business Working Group discussed Joint Policy #08-016 for Claims and Payment and agreed on the importance of updating the policy. TAMC will request assistance and guidance from MEDCOM if problems are encountered during the update process.

We anticipate a draft policy will be submitted to the Joint Venture Steering Group on 20 August 2013, and a final version will be sent to MEDCOM by 30 September 2013.

RECOMMENDATION 1.d.: Establish written procedures on roles and responsibilities for staff to research, review, and correct claims containing errors.

RESPONSE: Concur. TAMC will develop staff roles and responsibilities related to the Revenue Cycle, including VA Referral Center contact representatives/utilization management registered nurses (authorization/consult approval); clinical frontline medical service assistants; coders, and Uniform Billing Office and Accounts Receivable staff.. This information will be included in a Standard Operating Procedure to be presented to the TAMC Joint Venture working team for approval on 7 October 2013.

To preclude errors at the beginning of the revenue cycle, the Joint Venture Office developed an authorization flyer outlining procedures for processing both consults received from VAPIHCS and internally generated consults. The flyer was distributed to clinical staff.

In addition, to mitigate frequent turnover of frontline medical service assistants, TAMC instituted quarterly training. The training includes how to identify dual-eligible patients and a VA referral, as well as tips for booking the beneficiaries and entering the authorization.

RECOMMENDATION 1.e.: Update the Joint Policy #08-020 for Authorization to:

(1) Grant administrative privileges within Enhanced-Document and Referral Management System to Tripler Army Medical Center management to generate, adjust, or amend an authorization.

(2) Allow Tripler Army Medical Center the ability to properly bill Veterans Affairs Pacific Islands Health Care System for services rendered to its beneficiaries,

2

U.S. Army Medical Command Comments (cont'd)

regardless of whether Veterans Affairs Pacific Islands Health Care System provides an authorization.

(3) Standardize a shared methodology when calculating inpatient Level of Care days under the interagency sharing agreement.

RESPONSE: Non-concur. TAMC is unable to grant administrative privileges within the Enhanced-Document and Referral Management System (eDR) because that function is controlled by VAPIHCS. TAMC will request VAPIHCS to grant administrative privileges to TAMC management personnel, but cannot ensure agreement from VAPIHCS. The request will be made during an August 2013 Joint Business Working Group meeting.

In addition, it is inconsistent with regulatory guidance to allow TAMC to bill VAPIHCS for services rendered without proper authorization. AR 40-400, paragraph 3-23a(2) states, *Army MTFs will furnish medical care to a veteran on the basis of an authorization for treatment from the field station having jurisdiction. Reimbursement will not be made by the VA for medical care furnished prior to the effective date of the authorization, except as indicated in (3) below* (which addresses emergency medical care).

Shared methodology for calculating inpatient level of care days has been implemented . The contractor indicated the most current business rules are loaded in the VA Auth check web service, which pulls data from the Referral Management Inpatient Module of eDR and performs the level of care duration calculations.

RECOMMENDATION 1.f.: Reinstate the deleted claims and process the claims to Veterans Affairs Pacific Islands Health Care System for reimbursement of services rendered.

RESPONSE: Concur. The Joint Venture Office requested a list from the billing contractor and will review the list of claims deleted for straight K61 beneficiaries and reprocess valid claims. VAPIHCS indicated they will not process any retrospective authorizations for any period of time until they receive guidance from the Veterans Integrated Service Network (VISN). TAMC will request assistance and guidance from MEDCOM if necessary, but anticipates action will be complete by 31 December 2013.

RECOMMENDATION 1.g.: Review authorization failures more timely to ensure "Internal Entry Number" is properly linked to the appropriate appointment and the accuracy of data input. Claims containing authorization errors need to be resolved and processed.

RESPONSE: Concur. TAMC is reviewing options to address the recommendation, including hiring additional staff and/or making changes to eDR to automate linkage of authorizations to the internal entry number to address this issue. Due to sequestration, we anticipate action will be complete by 31 December 2014.

3

U.S. Army Medical Command Comments (cont'd)

RECOMMENDATION 1.h.: Elevate to U.S. Army Medical Command a request to review the reimbursement policy regarding the additional financial benefits provided to Veterans Affairs Pacific Islands Health Care System, coding disagreements, the use of Fee Based Claims System in denying Tripler Army Medical Center claims, and the delays in achieving approval by both parties. Additionally, Tripler Army Medical Center must elevate all unresolved recommendations (1.a to 1.h) in a timely manner to the U.S. Army Medical Command if Tripler Army Medical Center and Veterans Affairs Pacific Islands Health Care System management fail to achieve a negotiated solution.

RESPONSE: Concur. TAMC will elevate to MEDCOM requests to review the reimbursement policy regarding additional financial benefits and unresolved recommendations in a timely manner.

Professional fees were discussed during negotiations for the current FY 13 Reimbursement Methodology. TAMC reached an agreement with VAPIHCS to pay professional fees in accordance with the National Inpatient Reimbursement Methodology as of 1 April 2013 (the effective date of the new reimbursement methodology).

Medical coding was addressed at the Joint Business Working Group (JBWG), where new emphasis has been placed on the JBWG Coding and Billing sub-group, including review of the coding discrepancies identified by VAPIHCS during their claims review. A task log from the sub-group will be reviewed at JBWG meetings, and unresolved issues elevated to the Joint Venture Steering Group for decision.

VAPIHCS controls the Fee Based Claims System and informed TAMC that the VA Central Office denied a request to bypass the system for Joint Venture claims. TAMC will elevate this issue to MEDCOM.

These actions will be completed by 31 December 2013.

DODIG recommended the Commander, U.S. Army Medical Command:

RECOMMENDATION 2.a.: Elevate to DoD/Veterans Affairs Program Coordination Office a request to review the reimbursement policy regarding the additional financial benefits provided to Veterans Affairs Pacific Islands Health Care System, coding disagreements, the use of Fee Based Claims System in denying Tripler Army Medical Center claims, and the delays in achieving approval by both parties.

RESPONSE: Concur. As a follow up to the 17 December 2012 memorandum to ASD(HA), MEDCOM will request further assistance from ASD(HA) to resolve the remaining TAMC-VAPIHCS billing issues. The previous memorandum resulted in an

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U.S. Army Medical Command Comments (cont'd)

ASD(HA)-led workgroup that met with VA counterparts several times from January through March 2013. Some progress has been made; however, Department-level assistance is still required and will be requested by 31 August 2013.

RECOMMENDATION 2.b.: Direct Tripler Army Medical Center obtain contract oversight over the Accounts Receivable Management System-Professional billing system with Enhanced-Document and Referral Management System (ARMSPRO/eDR). This authority would allow Tripler Army Medical Center the needed administrative privileges over a DoD process.

RESPONSE: Nonconcur. TAMC cannot unilaterally obtain oversight for the current contract without obtaining consent from VAPIHCS. However, MEDCOM will direct TAMC to officially request administrative privileges for ARMSPRO/eDR).

In the event that VAPIHCS will not allow access, MEDCOM will direct Pacific Regional Medical Command to execute a contract line item number under the current contract for ARMSPRO used in Korea and Japan. The new line item will include transitioning the billing portion from the current contract to the new contract, and will enable TAMC to recognize receivables when corresponding revenue is earned in accordance with DOD Financial Management Regulation, Volume 4, Chapter 3. This will be an interim solution until the deployment of the Armed Forces Billing and Collection Utilization Solution (ABACUS). Once deployed, ABACUS will be the Army's billing platform and TAMC will be required to use the ABACUS billing process. Full deployment of ABACUS is expected by 31 December 2014.

COMMENTS ON POTENTIAL MONETARY BENEFITS: MEDCOM concurs with the potential monetary benefits of $33.6 million, as stated on page 29 of the draft report. However, the actual monetary benefits will be confirmed during the follow up process to ensure the recommendations were effectively implemented.

COMMENTS ON INTERNAL CONTROL WEAKNESSES: MEDCOM acknowledges DODIG's identification of internal control weaknesses as stated on page 3 of the draft report, and the intent to provide a copy of the report to the senior official responsible for internal controls in DA. Actions taken in response to the recommendations, as outlined above, should correct these weaknesses.

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Acronyms and Abbreviations

ARMS-Pro	Accounts Receivable Management System-Professional
DoD FMR	DoD Financial Management Regulation
DVPCO	DoD Veterans Affairs Program Coordination Office
E-DR	Enhanced-Document and Referral Management System
FBCS	Fee Based Claims System
LOC	Level of Care
MEDCOM	U.S. Army Medical Command
MSA	Master Sharing Agreement
PRMC	Pacific Regional Medical Command
TAMC	Tripler Army Medical Center
VA	Veterans Affairs
VAPIHCS	Department of Veterans Affairs Pacific Island Health Care System

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U.S. Department of Defense

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