



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audit of the Medical Care Collections Fund for VA-Provided Care

Audit

25-00148-252

October 26, 2026



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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to determine whether the Veterans Health Administration (VHA) effectively identified opportunities to recover medical costs for veterans who received VA-provided treatment for conditions unrelated to their military service and who have third-party health insurance. The Balanced Budget Act of 1997 established VA's Medical Care Collections Fund (MCCF) for amounts VA recovers from veterans' private (third-party) health insurance for treatment of conditions unrelated to their military service.¹ VA medical centers can access this fund to provide medical care and services to veterans. To assess accuracy, the audit team evaluated veterans' encounters with their VA medical providers from January 2024 through August 2025 (the audit period) that were coded in VA records as "reasons not billable" (RNB) to third-party insurers.

Although VA's revenue operations staff correctly identified an estimated 99 percent of nonbillable encounters for calendar year 2024, the OIG identified a significant discrepancy between RNB encounters in two VA systems—Veterans Health Information Systems and Technology Architecture (VistA) and the Corporate Data Warehouse (CDW). Although VistA is the main data source for CDW, the OIG team found encounter data in CDW that was not in VistA. Specifically, about 985,000 encounters coded as "RNB," valued at about \$1.9 billion, were missing from VistA RNB reports. Because these encounters were not included in the reports, revenue operations staff could not perform the second-level review required by VHA policy for monitoring RNB use to identify which records need to be corrected and processed for billing third parties.

The OIG shared preliminary results with VHA and the VA Office of Information and Technology (OIT) in December 2025 and in July 2026. Officials from VHA and OIT acknowledged the data were missing from the RNB reports. In July 2026, VHA and OIT officials acknowledged this is an ongoing issue and are working to identify the root cause of the problem and develop solutions. This audit reflects the OIG's commitment to providing VA with actionable recommendations to make the most effective use of taxpayer dollars to support healthcare services to veterans.

Based on VHA's input, the OIG team calculated that for the audit period, VHA could have collected up to \$480 million in revenue for encounters that were not captured by RNB reports, provided encounters were for non-service-connected care, the services provided were eligible for insurance billing, and the veterans had billable insurance. Ultimately, however, the OIG could not claim a reasonable monetary benefit for these encounters. VHA revenue operations staff said they do not track the number of incorrectly coded RNB encounters that could be corrected to a

¹ Pub. L. No. 105-33.

billable encounter, which is information that was needed to determine the monetary benefit. The OIG made three recommendations for VA to improve its guidance and oversight of the MCCF to ensure all eligible costs are recovered from veterans' private insurance. The acting under secretary for health concurred with all three recommendations.

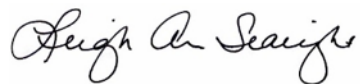
What the Audit Found

The OIG determined that VHA could improve oversight of patient encounters coded as RNB. For calendar year 2024, VHA staff correctly identified about 99 percent of the patient encounters as nonbillable to insurers (23 million of 23.2 million encounters). The other 1 percent of patient encounters were incorrectly identified as nonbillable. The incorrectly billed encounters were not considered relevant enough to rise to the level of an audit finding. As a result, the OIG did not make a recommendation on this issue but notified VHA so any collections could be made.

Revenue operations staff review VistA RNB reports to identify potential cost recoveries; however, the audit team found that RNB reports did not capture all patient encounters with an RNB code. The team determined that about 12.6 million of the 23.5 million patient encounters (53.8 percent (rounded)) identified in CDW with an assigned RNB code for calendar year 2024 were not on the VistA RNB reports. To determine whether this was an ongoing issue, the team extended its scope and found that an additional 8.6 million of 15.3 million reported patient encounters (57 percent (rounded)) from January through August 2025 were not on the VistA RNB reports. VHA relied on incomplete RNB data, creating a significant risk that leaders and revenue operations staff did not have all the information necessary to make informed decisions. These systemic data gaps between VistA and CDW expose VA to operational and oversight risks, which may prevent reliable financial and program management.

Next Steps

The OIG will monitor VHA's corrective actions and will close the recommendations when the administration provides sufficient evidence that the issues identified in this report have been addressed.



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Abbreviations

CDW	Corporate Data Warehouse
CPAC	Consolidated Patient Account Center
MCCF	Medical Care Collections Fund
OIG	Office of Inspector General
OIT	Office of Information and Technology
RNB	reasons not billable
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture



Introduction

The Veterans Health Administration (VHA) can recover veterans' healthcare costs by billing their third-party insurers if a VA-provided treatment is covered by the insurance company and is not connected to their military service. The Balanced Budget Act of 1997 established VA's Medical Care Collections Fund (MCCF) to hold the amounts VA recovers from third-party health insurers.² VA medical centers can access this fund to provide medical care and services to veterans. VA's MCCF collections for fiscal years 2024 and 2025 were \$3.8 billion and \$4.6 billion, respectively. VA estimated that the MCCF would receive \$4 billion in fiscal year 2026 and \$4.2 billion in fiscal year 2027.³

The VA Office of Inspector General (OIG) conducted this audit to review VHA processes and controls related to the MCCF. Specifically, the audit examined whether VHA effectively identified opportunities to recover VA-provided medical costs for veterans with third-party health insurance when veterans were treated for conditions unrelated to their military service. In conducting this audit, the team reviewed encounters coded as "reasons not billable" (RNB) in veterans' health record data from January 2024 through August 2025 (the audit period) for all medical facilities that used the Veterans Health Information Systems and Technology Architecture (VistA) electronic health records system. VA is transitioning from VistA to the updated Federal Electronic Health Record system, with full implementation anticipated in the year 2031.

This audit reflects the OIG's ongoing commitment to providing VA with actionable recommendations to make the most effective use of taxpayer dollars to support healthcare services to veterans. Historically, VHA has missed opportunities to collect revenue from third-party health insurance for VA-provided care. The OIG reported in 2012 that VHA did not effectively identify VA-provided episodes of care that could have increased its revenue by at least \$152 million annually between 2010 and 2014.⁴

Medical Care Costs

Under 38 U.S.C. § 1710, the VA Secretary is required to furnish hospital care and medical services needed to treat any veteran for a service-connected disability, including those who have service-connected disabilities rated at 50 percent or more, former prisoners of war, or those with conditions related to toxic exposure. Additionally, the statute allows for the Secretary to furnish medical services to treat non-service-connected conditions when resources are available. When

² Pub. L. No. 105-33.

³ VA FY 2027 Budget Submission, vol. 2, Medical Programs, April 2026, p. 4.

⁴ VA OIG, [Audit of VHA's Medical Care Collections Fund Billing of VA-Provided Care](#), Report No. 11-00333-254, August 30, 2012.

care is provided for health needs that are not service-connected, VA may recover the cost of that care from insurance companies.⁵ Patient encounters for VA-provided medical services that are not billable to veterans and insurance companies are assigned an RNB code, such as care for service-connected injuries, special authorities such as the PACT Act, Agent Orange exposures, or veterans without third-party insurance.⁶ Some RNB codes are system-generated, such as those for service-connected encounters. Other RNB codes are manually assigned by revenue operations staff. There were 79 unique active RNB codes in the audit universe.

Revenue Operations Responsibilities

The revenue operations office manages the centralized processes that allow VA to collect revenue from veterans' private health insurers. It is responsible for ensuring compliance with laws and regulations and for providing policy and guidance for collecting revenue. It also manages and executes revenue processes focused on billing and collections through its seven regional Consolidated Patient Account Centers (CPACs). Additionally, it is responsible for overseeing activities related to VHA's revenue program to standardize quality assurance monitoring and provide oversight.

Consolidated Patient Account Centers

Seven regional CPACs provide revenue management to VHA's Veterans Integrated Service Networks and their associated medical centers to support the MCCF program.⁷ CPACs perform the centralized processes necessary to collect revenue from veterans' private health insurers, which include verifying veterans' insurance and confirming that bills are processed and paid by third-party insurers. On December 15, 2025, the VA Secretary announced VHA's management structure would be reorganized over the next 18 to 24 months.⁸ At the time of this report's publication, the effect of this reorganization on the alignment and function of the CPACs is unknown.

⁵ 38 U.S.C. § 1729; 38 C.F.R. §§ 17.101 and 17.106.

⁶ Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022, Pub. L. No. 117-168, 136 Stat. 1759.

⁷ In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the under secretary for health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to five. On July 15, 2026, the acting under secretary for health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's audit. For more information on this initiative, visit <http://digital.va.gov/rise/>.

⁸ VA Secretary, "Veterans Health Administration (VHA) Reorganization," memorandum to the Department of Veterans Affairs, December 15, 2025.

Facility Revenue

At medical facilities, revenue department staff serve as liaisons to connect veterans, medical center staff, and CPAC staff to gather eligibility, insurance, scheduling, and other administrative information about veterans' visits. VHA's policy for monitoring RNB codes requires that each facility revenue manager review patient encounters with RNB codes to identify potential billable encounters.⁹ According to the VHA *Site Classifications and Definitions* handbook, a patient encounter is a professional contact between a veteran who is a patient and their VA medical provider who is authorized to diagnose, evaluate, or treat them.¹⁰ Monthly, the facility revenue managers run a detailed report in VistA for their VA medical centers. The report is a consolidated list of patient encounters assigned an RNB code, meaning that the encounter is not billable to third-party insurers. Facility managers are required to review the report for five specific RNB codes and to review all inpatient encounters to confirm the codes are correctly assigned. If the encounters are miscoded, facility revenue staff work with CPAC staff to correct them.

Veterans Health Information Systems and Technology Architecture

VistA is a health information system and electronic health record owned by VA's Office of Information and Technology (OIT). One of VistA's software packages is integrated billing for patient encounters.

Corporate Data Warehouse

The Corporate Data Warehouse (CDW) is another VA OIT system. According to VA, the main data source for CDW on health care is VistA.

⁹ VHA policy P-04-02-01, *Revenue Operations Monitoring "RNB,"* updated June 25, 2025; VHA Directive 1600 (1), *Monitoring "Reasons Not Billable,"* amended March 20, 2024.

¹⁰ VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

Results and Recommendations

Finding: VHA Has an Opportunity to Enhance Review Controls for Patient Encounters

The audit team estimated that VA correctly identified 99 percent of RNB encounters (about 23 million of 23.2 million encounters) for calendar year 2024 as nonbillable. However, the OIG identified about 985,000 RNB encounters with mandatory review requirements that were not contained in the VistA RNB reports, which impeded revenue operations staff from reviewing all patient encounters. The data were in a different repository (CDW) than the database from which the reports were generated (VistA), even though VistA is the main data source for CDW. By reviewing encounters found in CDW that were not captured by RNB reports, VHA could collect up to \$480 million in additional revenue for the MCCF that ultimately could be used for veterans' medical care, provided encounters were for non-service-connected care, the services provided were eligible for insurance billing, and veterans had billable insurance.¹¹

What the OIG Did

The audit team reviewed applicable laws, regulations, policies, and procedures related to identifying, reviewing, and monitoring encounters with an RNB code at all levels of VHA. The team pulled CDW patient encounter data that had assigned RNB codes and obtained data from 170 VistA RNB reports for calendar year 2024 for all seven CPACs. The team compared CDW data with the RNB reports to determine whether all patient encounters were captured on the RNB reports. After finding that not all encounters were captured on the RNB reports, the team expanded its review to include January through August 2025 to determine whether the VistA reporting issues observed from calendar year 2024 persisted.

The team also selected a stratified sample of 637 patient encounters coded as RNB from VistA and CDW for calendar year 2024 to determine whether the use of the RNB codes was appropriate and whether VHA should have billed veterans' private health insurers. To evaluate how staff identified, reviewed, and monitored encounters with an RNB code, the team interviewed officials from revenue operations, CPACs, and OIT. For more information about the audit's scope and methodology, see appendix A. Appendix B provides more information about the team's statistical methodology.

Accuracy of RNB Codes

The OIG determined that VHA correctly identified about 23 million of 23.2 million patient encounters (99 percent) as not billable for calendar year 2024. The other 1 percent of patient

¹¹ The additional revenue is discussed further in the "Opportunities to Collect Revenue" section of this report.

encounters were incorrectly identified as nonbillable, which was not considered relevant enough to rise to the level of an audit finding. As a result, the OIG did not make a recommendation for this issue but provided the encounters to VHA so any collections could be made.

Patient Encounters Not Found on RNB Reports

The OIG determined that approximately 12.6 million of about 23.5 million patient encounters (53.8 percent (rounded)) identified in CDW with an assigned RNB code for calendar year 2024 were not included on VistA RNB reports. Because the RNB reports are used to identify opportunities to recover medical costs, incomplete RNB reports did not allow revenue operations staff to fully identify and potentially take action on approximately 12.6 million encounters during calendar year 2024.

The team expanded its scope to include patient encounters from January through August 2025 to find out whether problems the team observed from calendar year 2024 persisted. The team found that approximately 8.6 million of about 15.2 million encounters (57 percent (rounded)) identified in CDW for that eight-month period were not on the RNB reports. VHA relied on incomplete RNB data without realizing that millions of encounters were missing from VistA reports, creating a significant risk that leaders and revenue operations staff did not have all the information necessary to make informed decisions. Being unaware of the systemic data gaps between VistA and CDW exposes VA to operational and oversight risks and impedes timely identification and correction of reporting failures necessary for reliable financial and program management.

In December 2025, the team briefed VHA and OIT officials on this issue and provided data and analysis to help VA replicate data and evaluate the findings. The officials acknowledged that data were missing from the RNB reports. As of July 2026, officials stated they were working to identify the root cause of the problem and develop solutions for the revenue operations team.

To formalize the OIG's request for those findings and any subsequent actions planned or taken, recommendation one calls for VHA and OIT to complete their analysis on missing patient encounters with RNB codes and implement a planned solution.

Recommendation two calls on VHA to provide guidance and oversight to ensure RNB reports have accurate and complete patient encounter data.

Revenue Operations Staff Validation of VistA RNB Reports

Revenue operations staff, including staff from CPACs, facility revenue, and quality assurance, said they have access to VistA and several other systems to review patient encounters and run reports to perform RNB reviews. However, staff from revenue operations and CPACs told the OIG team that they did not have access to CDW and did not validate whether RNB reports from

VistA are complete and accurate. In addition, they said they were unaware that there were patient encounters with RNB codes in CDW that did not appear on the VistA RNB reports.

Although VHA's policy for monitoring RNB use does not require staff to compare or validate the accuracy and completeness of VistA reports with CDW data, the Government Accountability Office's *Standards for Internal Control in the Federal Government* states that management should design control activities to mitigate risks to achieve effective information processing for the completeness, accuracy, and validity of data.¹² According to these standards, management should evaluate processed information to determine whether it is complete, appropriate, and accurate. Furthermore, according to VHA Directive 1600(1), the revenue operations executive director is responsible for providing oversight and guidance on the use of RNB codes.¹³

Opportunities to Collect Revenue

The OIG determined that incomplete RNB reports resulted in missed opportunities to recover MCCF revenue of up to approximately \$480 million (\$191 million during calendar year 2024 and \$289 million from January through August 2025), provided encounters were for non-service-connected care, the services provided were eligible for insurance billing, and veterans had billable insurance. Facility revenue managers are required to review the reports for five specific RNB codes and all inpatient encounters monthly to confirm that these codes are correctly assigned.¹⁴ Overall, the OIG identified about 985,000 additional CDW RNB encounters, valued at about \$1.9 billion, that should have been reviewed yet were not on VistA RNB reports (254,377 encounters from calendar year 2024, valued at approximately \$763.8 million, and 730,898 encounters from January through August 2025, valued at about \$1.2 billion).

The increase in CDW encounters from 2024 to 2025 was due to substantial increases in encounters for two RNB codes for which the policy mandated review, one of which was added for calendar year 2025. Because these encounters were missing from the mandatory RNB review reports, staff could not identify whether codes needed to be corrected on encounters that should be processed for billing. According to 38 U.S.C. § 1729, VA may not recover or collect from insurance companies after six years from the last day on which care or services are provided.¹⁵

To develop the audit's monetary impact, the OIG shared its data and methodology with VHA revenue operations managers. Although VHA recommended a method for determining potential impact, VHA used a dataset to calculate potential additional revenue that was different from the

¹² Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-25-107721, May 2025.

¹³ VHA Directive 1600(1), *Monitoring "Reasons Not Billable,"* March 5, 2021, amended March 20, 2024.

¹⁴ VHA policy P-04-02-01, *Revenue Operations Monitoring "RNB,"* issued July 29, 2020, and updated June 25, 2025, required by VHA Directive 1600(1).

¹⁵ Recovery by the United States of the Cost of Certain Care and Services, 38 U.S.C. § 1729, January 2019, section 1729A, updated July 2026.

one that the OIG used. Specifically, the OIG's analysis looked at all encounters with RNB codes and VHA's analysis did not, with the result that the OIG's and VHA's work was not compatible for comparison.

The OIG then replicated VHA's basic methodology on each individual RNB-coded encounter in the audit universe's dataset. VHA suggested applying its MCCF historical collections-to-billing rates, which averaged 31.6 percent for inpatient care and 32.9 percent for outpatient care billings for fiscal years 2024 and 2025, respectively. In addition to applying the collections-to-billing rates, the OIG attempted to identify an appropriate metric to estimate the percentage of incorrectly coded nonbillable encounters; however, VHA's internal audit manager stated they do not track the number of incorrectly coded RNB encounters that could be corrected to a billable encounter. Without this information, the OIG could not claim a reasonable monetary benefit for these encounters and did not claim the \$480 million as a monetary benefit of the audit. However, the OIG believes that VHA has an opportunity to collect additional revenue up to \$480 million and prevent future revenue loss upon correction of system reporting.

Recommendation three calls for VHA to review encounters excluded from VistA RNB reports for potentially billable encounters and, if appropriate, bill insurance companies for revenue for the period allowed by 38 U.S.C. § 1729.

Conclusion

The OIG determined that VHA correctly identified an estimated 99 percent of patient encounters (about 23 million of 23.2 million encounters) as not billable for calendar year 2024. However, to fully realize potential collections, VHA needs to improve oversight and controls over its review of patient encounters coded as RNB, given that about half were not reported on VistA RNB reports in 2024 and in the eight-month period examined in 2025. The team estimated that VHA could have missed opportunities to collect up to \$480 million in revenue that could be used to support healthcare services for veterans, provided encounters were for non-service-connected care, the services provided were eligible for insurance billing, and veterans had billable insurance. By implementing the OIG's recommendations to identify and correct VistA reporting functions, VHA will make better use of taxpayer dollars, improve its ability to provide healthcare services, and minimize the risk of overlooking revenue it is due.

Recommendations 1–3

The OIG made one recommendation to the under secretary for health and the assistant secretary for Information and Technology to take appropriate actions to do the following:¹⁶

1. Provide findings on the analysis of why Veterans Health Information Systems and Technology Architecture reports do not capture all patient encounters with a reasons-not-billable code and implement a plan to capture all encounters being reported outside that system.

The OIG made two recommendations to the under secretary for health to take appropriate actions to do the following:

2. Provide guidance and oversight to ensure reasons-not-billable reports have accurate and complete patient encounter data.
3. Review encounters excluded from Veterans Health Information Systems and Technology Architecture reasons-not-billable reports for potentially billable encounters and, if appropriate, bill insurance companies for revenue for the period allowed by 38 U.S.C. § 1729.

VA Management Comments

The acting under secretary for health concurred with all three recommendations and provided an action plan. OIT did not provide a separate response; however, the GAO/OIG Accountability Liaison Office stated that OIT consolidated its response with VHA's. For recommendation one, the acting under secretary for health said that revenue operations staff will work with OIT to determine why VistA reports do not capture all patient encounters with RNB codes and will implement a plan to capture all encounters that are being reported outside VistA. To meet recommendation two, revenue operations staff plan to develop a new RNB report using CDW as the data source to ensure accurate patient encounter data. Regarding recommendation three, revenue operations staff will use CDW data to review encounters with mandatory and high-risk RNB codes to determine the error rate and potential corrective actions. The full text of the management comments is provided in appendix C.

OIG Response

VHA's planned actions are responsive to the recommendations. The OIG will close the recommendations when VHA provides sufficient documentation demonstrating that these actions have been fully implemented and have addressed the issues identified in this report.

¹⁶ The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from April 2025 through September 2026. The team audited inpatient and outpatient encounters from January 2024 through December 2024 to determine how effectively the Veterans Health Administration (VHA) billed veterans' private health insurers for medical care or services provided by VA facilities for treatment of conditions unrelated to military service. The team expanded its initial scope through August 2025 in response to the results of its sample testing. The expanded scope included inpatient and outpatient encounters for January 2025 through August 2025 to determine whether reporting issues noted in calendar year 2024 Veterans Health Information Systems and Technology Architecture (VistA) reasons-not-billable (RNB) reports continued to occur.

Methodology

The OIG team identified and assessed applicable laws, regulations, VA policies, operating procedures, and guidelines to understand the Medical Care Collections Fund (MCCF) program. The team also interviewed officials from the VHA Office of Finance revenue operations and Consolidated Patient Account Centers (CPACs) to obtain information about billing and recovering funds from veterans' private insurers. To evaluate MCCF recoveries, the team examined a stratified probability proportional to size sample of inpatient and outpatient encounters with RNB codes during calendar year 2024. The sample was stratified by subpopulation, CPAC, and encounter cost. The sample review included comparing VistA reports to Corporate Data Warehouse (CDW) records for RNB encounters. Records were selected with probability proportional to size based on the total dollar amount associated with each RNB code within each stratum.

The team analyzed the sample and obtained additional supporting documentation when needed to determine whether the use of the RNB codes was appropriate and whether the encounter should have been billed to an insurance company. The OIG's statistical operations team then estimated the count and percentage of missed billing opportunities and related dollar amounts. Based on the VistA reported data, they estimated the missing values for patient encounters found in CDW only by location, RNB code, and primary stop code. The sample results were further refined to include an estimate for billable samples with errors that required a review according to policy. The estimate contained encounters found in both the VistA reports and in CDW.

The OIG's statistical operations team analyzed the audit universe to understand the difference between the CDW and VistA datasets for calendar year 2024. Analytical testing was expanded to include January 2025 through August 2025 but was limited to universe analysis to determine whether the difference observed between CDW and VistA continued using the same

methodology and to quantify the number of missed billing opportunities and related dollar amounts. To estimate the monetary impact of the audit’s findings, VHA’s internal audit manager suggested taking the averages of all inpatient and outpatient encounters multiplied by the missing encounters. He also suggested that the OIG apply VA’s MCCF historical collections-to-billing rate, which averaged 31.6 percent for inpatient care and 32.9 percent for outpatient care billings for fiscal years 2024 and 2025. Using this methodology, the OIG team estimated VHA could collect up to \$480 million in potential revenue, provided encounters were for non-service-connected care, the services provided were eligible for insurance billing, and veterans had billable insurance.

Internal Controls

The team assessed VHA’s internal controls to determine whether they were significant to the audit objective. This included consideration of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.¹⁷ In addition, the team reviewed the principles of internal controls associated with the objective and identified two components and two principles as significant.¹⁸ The team identified internal control deficiencies during this audit and proposed recommendations to address those listed in table A.1.

Table A.1. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this audit
Control environment	2. The oversight body should oversee the entity’s internal control system.	VHA lacked effective controls over the RNB process because RNB reports were missing data; therefore, officials could not review all required encounters. Complete and accurate data would have allowed VHA to recover additional revenue from insurance companies.
Information and communication	13. Management should use quality information to achieve the entity’s objectives.	VHA system reports were not complete and reliable to perform thorough reviews of encounters with RNB codes.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the Government Accountability Office’s Standards for Internal Control in the Federal Government.

¹⁷ Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

¹⁸ Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that could have existed at the time of this audit.

Data Reliability

Computer-processed data were central to the audit. For calendar year 2024, the CDW data extraction was conducted by OIG statisticians with a code peer review by OIG Office of Data and Analytics staff, with no material issues identified. Submissions of the VistA RNB reports from VHA in the January 2025 data request were also reviewed by the OIG audit team for completeness and conformance to the requested procedures. Once the universe had been developed from the CDW extraction and OIG statisticians compiled the VistA RNB report, the audit team conducted detailed testing on the two subpopulations. Although this was one universe, the team decided to test the subpopulations independent of each other and did not find any material errors that would affect the audit. The team conducted the same data reliability testing for the data from January 2025 through August 2025. The results of testing for both periods were sufficiently reliable for the audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards.¹⁹ Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

¹⁹ Government Accountability Office, *Government Auditing Standards*, GAO-24-106786, February 2024.

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the objective, the VA Office of Inspector General (OIG) team reviewed a statistical sample of veterans’ records and related financial transactions associated with “reasons not billable” (RNB) coding during calendar year 2024. The team used statistical sampling to quantify whether the transactions could be located, whether they were fairly presented, and whether the associated RNB codes were appropriate.

Population

The original population included 23,689,797 inpatient and outpatient records with an attributed RNB code from January 2024 through December 2024 identified from the Corporate Data Warehouse (CDW) and Veterans Health Information Systems and Technology Architecture (VistA) RNB reports. The team excluded 211,778 records (0.9 percent). Examples of excluded encounters are the RNB-only population, those in the Federal Electronic Health Record, and select RNB codes relating to pharmacy and prosthetics.

The scope was expanded to determine whether problems from calendar year 2024 also occurred in 2025. The expanded population included 15,156,082 inpatient and outpatient records with an attributed RNB code from January 2025 through August 2025, with 161,485 encounters (1 percent) excluded due to not meeting materiality thresholds.

The team reviewed the following populations. For both tables B.1 and B.2, the team estimated the dollar amount for the RNB encounters recorded in CDW based on VistA data because the CDW data did not include dollar values associated with each encounter. Where the VistA RNB report values were present, they were used instead of the estimated values.

Table B.1. Populations of RNB-Coded Encounters from January 2024 through December 2024

Population of RNB encounters	Number of RNB encounters	Percentage of RNB encounters	Dollar amount	Percentage of dollar amount
CDW and VistA	10,844,976	46.2%	\$10,416,430,080.64	48.0%
CDW only	12,633,043	53.8%	\$11,284,378,180.52	52.0%
Total	23,478,019	—	\$21,700,808,261.16	—

Source: VA OIG statistician’s population from CDW and VistA reporting. Percentages are rounded.

Table B.2. Populations of RNB-Coded Encounters from January 2025 through August 2025

Population of RNB encounters	Number of RNB encounters	Percentage of RNB encounters	Dollar amount	Percentage of dollar amount
CDW and VistA	6,510,086	43.0%	\$6,734,042,653.87	41.1%
CDW only	8,645,996	57.0%	\$9,664,147,887.49	58.9%
Total	15,156,082	—	\$16,398,190,541.36	—

Source: VA OIG statistician's population from CDW and VistA reporting. Percentages are rounded.

Sampling Design

The team selected a stratified sample of 637 encounters from the population of records with an assigned RNB code for calendar year 2024. Samples were selected with probability proportional to the total cost associated with each encounter. The population was divided into 53 strata by the subpopulations included in table B.1, CPAC, and monetary value, as shown in tables B.3 and B.4.

The expanded universe was not sampled but was analyzed by reproducing the universe level initial design and subsequent analysis. No projections were made on the expanded universe for January 2025 through August 2025.

Table B.3. Stratified Sample for the CDW and VistA-Matched Subpopulation

Stratum	Consolidated Patient Account Center	Dollar value strata	Total unique encounters	Total encounter value	Sampled encounters
1	Central Plains	1-\$0.00 to \$10,000	1,610,172	\$850,104,400.68	25
2	Central Plains	2-\$10,000 to \$100,000	11,165	\$268,254,927.20	8
3	Central Plains	3-\$100,000 to \$500,000	581	\$100,403,891.04	3
4	Central Plains	4-≥\$500,000	27	\$23,387,419.87	2
5	Florida/Caribbean	1-\$0.00 to \$10,000	987,140	\$644,735,470.27	19
6	Florida/Caribbean	2-\$10,000 to \$100,000	8,477	\$210,014,027.91	7
7	Florida/Caribbean	3-\$100,000 to \$500,000	676	\$128,856,457.80	4
8	Florida/Caribbean	4-≥\$500,000	53	\$46,859,748.19	2

Stratum	Consolidated Patient Account Center	Dollar value strata	Total unique encounters	Total encounter value	Sampled encounters
9	Mid Atlantic	1-\$0.00 to \$10,000	1,848,803	\$1,190,001,966.67	35
10	Mid Atlantic	2-\$10,000 to \$100,000	14,008	\$303,892,585.58	9
11	Mid Atlantic	3-\$100,000 to \$500,000	461	\$85,141,931.08	3
12	Mid Atlantic	4-≥\$500,000	42	\$37,443,817.80	2
13	Mid South	1-\$0.00 to \$10,000	1,876,447	\$1,312,933,173.59	38
14	Mid South	2-\$10,000 to \$100,000	17,436	\$411,450,214.65	12
15	Mid South	3-\$100,000 to \$500,000	1,045	\$192,234,978.31	6
16	Mid South	4-≥\$500,000	71	\$78,673,337.21	3
17	North Central	1-\$0.00 to \$10,000	1,155,308	\$604,632,589.81	18
18	North Central	2-\$10,000 to \$100,000	7,952	\$198,655,957.64	6
19	North Central	3-\$100,000 to \$500,000	570	\$104,727,345.23	4
20	North Central	4-≥\$500,000	30	\$21,871,025.39	2
21	North East	1-\$0.00 to \$10,000	1,674,123	\$891,596,222.60	26
22	North East	2-\$10,000 to \$100,000	10,975	\$275,193,328.46	8
23	North East	3-\$100,000 to \$500,000	939	\$174,466,320.36	6
24	North East	4-≥\$500,000	62	\$48,919,560.76	2
25	West	1-\$0.00 to \$10,000	1,596,613	\$1,279,633,544.33	37
26	West	2-\$10,000 to \$100,000	20,320	\$476,992,999.39	14
27	West	3-\$100,000 to \$500,000	1,327	\$260,176,929.39	8
28	West	4-≥\$500,000	153	\$195,175,909.43	6
Total	—	—	10,844,976	\$10,416,430,080.64	315

Source: VA OIG statistician's stratified population from CDW and Vista reporting.

Table B.4. Stratified Sample for the CDW-Only Subpopulation

Stratum	Consolidated Patient Account Center	Dollar value strata	Total unique encounters	Total encounter value	Sampled encounters
29	Central Plains	1-\$0.00 to \$10,000	1,799,419	\$1,231,139,300.29	33
30	Central Plains	2-\$10,000 to \$100,000	5,322	\$102,419,235.22	3
31	Central Plains	3-\$100,000 to \$500,000	166	\$26,855,609.22	2
	Central Plains	4-≥\$500,000	0	0	0
32	Florida/Caribbean	1-\$0.00 to \$10,000	1,187,577	\$926,869,993.88	25
33	Florida/Caribbean	2-\$10,000 to \$100,000	3,298	\$109,948,706.33	3
34	Florida/Caribbean	3-\$100,000 to \$500,000	224	\$26,694,786.23	2
35	Florida/Caribbean	4-≥\$500,000	5	\$2,982,477.65	2
36	Mid Atlantic	1-\$0.00 to \$10,000	2,322,778	\$1,659,872,192.15	45
37	Mid Atlantic	2-\$10,000 to \$100,000	14,111	\$375,070,186.69	10
38	Mid Atlantic	3-\$100,000 to \$500,000	347	\$66,344,933.64	2
39	Mid Atlantic	4-≥\$500,000	2	\$1,522,374.10	2
40	Mid South	1-\$0.00 to \$10,000	2,333,105	\$1,846,593,872.30	50
41	Mid South	2-\$10,000 to \$100,000	17,397	\$328,331,694.99	9
42	Mid South	3-\$100,000 to \$500,000	110	\$15,764,378.34	2
43	Mid South	4-≥\$500,000	18	\$21,330,073.41	2
44	North Central	1-\$0.00 to \$10,000	1,234,082	\$799,076,613.84	22
45	North Central	2-\$10,000 to \$100,000	14,557	\$255,072,255.53	7
46	North Central	3-\$100,000 to \$500,000	20	\$2,484,680.91	2
	North Central	4-≥\$500,000	0	0	0
47	North East	1-\$0.00 to \$10,000	1,762,633	\$1,073,205,190.65	29

Stratum	Consolidated Patient Account Center	Dollar value strata	Total unique encounters	Total encounter value	Sampled encounters
48	North East	2-\$10,000 to \$100,000	5,151	\$124,457,933.18	4
49	North East	3-\$100,000 to \$500,000	198	\$36,991,339.47	2
	North East	4-≥\$500,000	0	0	0
50	West	1-\$0.00 to \$10,000	1,904,412	\$1,657,160,408.35	45
51	West	2-\$10,000 to \$100,000	27,784	\$537,375,523.24	15
52	West	3-\$100,000 to \$500,000	323	\$53,990,679.85	2
53	West	4-≥\$500,000	4	\$2,823,741.06	2
Total	—	—	12,633,043	\$11,284,378,180.52	322

Source: VA OIG statistician's stratified population from CDW and VistA reporting.

Weights

Samples were weighed to represent the population from which they were drawn, and the weights were used in the estimate calculations. The team used statistical analysis software to calculate the error rate estimates through modeling of the probability proportion to size method.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value about 90 percent of the time.

The OIG statistician used statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design. The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistic concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Projections

As shown in table B.5, the team projected sample results across the universe of RNB-coded inpatient/outpatient encounters during calendar year 2024. Specifically, the team used the sample results to estimate the value of encounters that appeared to be coded correctly. Beyond the

general sample results, the sample was further refined to include an estimate for billable samples with errors that were mandated to be reviewed. Due to the low number of sampled encounters meeting the criteria, the reported estimate is a one-sided lower bound. The team applied the VHA-provided MCCF historical collections-to-billing rate for outpatient encounters during 2024 of 33.2 percent to the estimate, which resulted in a potential collectible amount of 4.6 percent.

Table B.5. Statistical Projections Summary for Correctly RNB-Coded Encounters, (90 Percent Confidence Interval)

Estimate name	Estimate number	Margin of error	Lower limit Upper limit	Sample size* (sample count)	Rounded estimate
Encounters correctly coded as nonbillable (percent)	22,981,053 (99.1)	415,325 (0.7)	22,565,728 (98.4) 23,396,378 (99.8)	635 (627)	23 million (99)
Encounters incorrectly coded as nonbillable (percent)	213,500 (0.9)	129,999 (0.6)	83,502 (0.4) N/A	635 (8)	83,500 (0.3)
Value of encounters correctly coded as nonbillable	\$20,555,896,518	\$302,129,398	\$20,253,767,120 \$20,858,025,916	635 (600)	\$21 billion
Value of encounters incorrectly coded as nonbillable	\$790,868,489	\$261,409,479	\$529,459,010 \$1,052,277,968	635 (27)	\$790 million
Value of encounters incorrectly coded as nonbillable, required to be reviewed by VHA policy	\$281,282,696	\$126,502,284	\$154,780,412 N/A	635 (8)	\$150 million

Source: VA OIG statistician's projections.

* The audit team could identify 635 of 637 patient encounters in the sample.

Appendix C: VA Management Comments, Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: September 2, 2026

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Report, Audit of Medical Care Collections Fund for Veterans Affairs (VA) Provided Care (VIEWS 15174484).

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on OIG's draft report on Audit of Medical Care Collections Fund for VA-Provided Care. The Veterans Health Administration (VHA) concurs with the recommendations made to the Under Secretary for Health and provides an action plan in the attachment.
2. VHA is committed to continuous improvement and appreciates OIG's review. The information provided in this report will be used to maximize revenue recovery and data integrity. Your collaboration is instrumental in helping us achieve our commitment to excellence in health care services for Veterans.

<i>The OIG removed point of contact information prior to publication.</i>

(Original signed by)

John Figueroa

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report – Audit of Medical Care Collections Fund for VA-Provided Care (Project No. 2025-00148-AE-0008)

Recommendation 1: Provide findings on the analysis of why Veterans Health Information Systems and Technology Architecture reports do not capture all patient encounters with a reasons-not-billable code and implement a plan to capture all encounters being reported outside that system.

VHA Comments: Concur. Revenue Operations will work with VA Office of Information and Technology (OIT) to determine why Veterans Health Information Systems and Technology Architecture (VistA) reports do not capture all patient encounters with a reasons-not-billable code and implement a plan to capture all encounters being reported outside that system.

Status: In-Progress **Target Completion Date:** November 2026

Recommendation 2: Provide guidance and oversight to ensure reasons-not-billable reports have accurate and complete patient encounter data.

VHA Comments: Concur. A new Reasons-Not-Billable report is in development by Revenue Operations and is expected to be completed by December 2026. This report will use Corporate Data Warehouse (CDW) as the data source to ensure accurate and comprehensive patient encounter information. Once finalized, standard operating procedures (SOPs), internal controls, and applicable operational procedures will be updated to reflect the revised process. The Revenue Operations oversight teams will monitor compliance with these SOPs and controls to ensure consistent processes and timely report completion.

Status: In-Progress **Target Completion Date:** January 2027

Recommendation 3: Review encounters excluded from Veterans Health Information Systems and Technology Architecture reasons-not-billable reports for potentially billable encounters and, if appropriate, bill insurance companies for revenue for the period allowed by 38 U.S.C. § 1729.

VHA Comments: Concur. Revenue Operations will conduct a strategic review of mandatory and high-risk reasons-not-billable categories, using CDW as the data source. This review will involve analyzing a statistically valid sample to determine the error rate in selected categories. Revenue Operations will collaborate with OIG to determine the appropriate sample size and sampling methodology. If the error rate is ≤ 5%, no further action will be taken. If the error rate exceeds 5%, corrective actions will include additional staff training, revisions to SOPs, internal controls, or policies, and enhanced oversight by the Revenue Operations oversight teams.

Status: In-Progress **Target Completion Date:** January 2027

*The text of VHA's management comments is reprinted verbatim as received from the department.
For accessibility, the original format of this appendix has been modified
to comply with section 508 of the Rehabilitation Act of 1973, as amended.*

OIG Contact and Staff Acknowledgments

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