VA'S MEDICAL CARE COLLECTION FUND

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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VA'S MEDICAL CARE COLLECTION FUND

THURSDAY, SEPTEMBER 20, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:10 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Bilirakis, Carson, and Udall.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. This hearing will come to order. Good morning. The tragedy we all experienced on September 11, 2001, not only at the World Trade Center, but at the Pentagon, a little over 3 miles from here, and in the Pennsylvania countryside, I believe shocked the conscience of a Nation. As we mourn and begin to define our resolve, it is important that as America gets back to work, so do we. My comfort is that the government is working and that as of this past Thursday, when we sent $40 billion to the President of the United States, to assist in the cleanup efforts at the Pentagon and in New York, it highlights the importance of a government to run efficiently.

So as the focus is upon present operations, as we seek to attain justice for what had occurred on our own soil, and to move in concert with other nations, it also is a reminder to us of the past. We must make sure that we do care for those who have made great sacrifices for the Nation. The hearing today will focus on the oversight of the VA's management of the medical care collection fund, how we bring dollars back into the VA that rightfully belong to the VA and how it as a system is doing.

It is abysmal. It is very poor. This is the subcommittee's second hearing on the medical care collection fund. In September 1999, the subcommittee heard from various witnesses about the management problems at the VA related to the MCCF. The former VHA chief financial officer stated at that time that the Department had put several initiatives in place to address its poor performance. In April of 2001, almost 2 years later, the full committee also questioned the VA's continued inability to effectively collect. At the hearing, Secretary Principi stated, "I also believe we need to do a better job in medical care cost recovery. You have given us the right to retain those dollars in the VA medical care system and every dollar we leave on the table, that which we don't collect because of poor management, or whatever the case might be, is a dollar that doesn't go

to VA health care, and to me that is unacceptable. You know, we have been at this now for over 10 years. I just believe that we haven't quite got it right. It is something that was never part of our core mission, never part of the culture, the institution of the VA, and we simply have not been aggressive enough in collecting the dollars.

No kidding. Today we will hear the views from representatives from the General Accounting Office, the VA Inspector General, the private sector leaders in the field of third party payer collections, and representatives from the Department of Veterans Affairs. Through their testimony, we should be able to get an idea of what progress the VA has made in fixing the problems that were identified 2 years ago, and still what might be done to further improve the performance of the MCCF.

At this point, I would like to thank the Veterans' Service Organizations that submitted a statement for the record. Their participation in this process is extremely important, but I would like to say this to any of the representatives of the veteran service organizations that are here: I know that you are given up to 5 days from the date of a hearing to submit your testimony. It is extremely helpful to those of us on the committee if you submit your testimony prior to the hearing. We sit down, we are good students, we read these statements to help us prepare for the hearing, and when I don't get those statements ahead of time, it is hard. I mean, I can read them after the fact, but it is much better if I get them ahead of time.

The Vietnam Veterans of America submitted a statement and I want to thank them. This is a very good statement that I went through last night. Today, we are going to revisit many of the issues that were brought up in the first hearing which the VA said it would address. In the 2 years since that hearing, a number of Inspector General reports have been issued that detail the apparent lack of progress that the VA has made. I suspect this will be further evidenced by the findings of the General Accounting Office.

The VA annually estimates how much it will take in through the MCCF, and it factors that into its yearly budgetary request to Congress. Annually, the VA has grossly overestimated its revenues. This then leads to the VA coming back to Congress to complain that it hasn't received enough funding. I am glad to see that because of the VA's adoption of the "reasonable charge" system, the collection of revenues have gone up, and this year it looks like they will meet their projections.

This is truly a positive turn of events. Because of this I am hopeful that the VA will not have to come to Congress asking for supplemental funding. However, I am disturbed that it appears that the VA has not eliminated many of the problems that have plagued the MCCF over the years. The way that documentation of the medical treatment is carried out and the way that the treatment is coded for billing purposes has serious problems.

Additionally, the tremendous backlog of claims, and the estimated values, filed with insurance companies can at times be mind numbing. The time it takes for most medical centers to prepare a bill and submit it to insurance companies is unacceptable. The re-

cent Combined Assessment Program Review that the IG issued on the VA Tennessee Valley Health Care System illustrates my point.

How am I as chairman of the VA Oversight and Investigations Subcommittee supposed to tell Zack Wamp of Tennessee, that the veterans in his District have been deprived of $10.5 million over the past 2 years because of an enormous backlog of 70,205 claims? Quite frankly, I don't know what the answer is. However, I do know that this committee wants to stress that we are hoping to get some answers regarding exactly what the VA intends to do about these unacceptable circumstances.

The millions of dollars the VA, and by extension the veterans themselves, don't see could be used for a multitude of things to improve the level of care and treatment within the VA. As gloomy as all of this sounds, some MCCF directors at various medical centers have truly done a good job in managing their funds, and their work should be recognized. Also, there are private sector companies that specialize in third party collections.

We look forward to the hearing their suggestions regarding the ways to improve this system. After this hearing, I hope that the VA will undertake a serious review of the way MCCF is administered. I expect them to make changes to the aspects of the system that don't work and seek ways to integrate the successful techniques that we hear about today into a standard operating procedure for the program.

[The prepared statement of Congressman Buyer appears on p. 37.]

Mr. BUYER. We have a full schedule, and we have a full committee hearing immediately following this subcommittee hearing; so I will now recognize the ranking Democrat on the subcommittee, Ms. Carson, for any comments she'd like to make.

OPENING STATEMENT OF HON. JULIA CARSON

Ms. CARSON. Thank you, Mr. Chairman, and I thank the panel, certainly those who are gathered here today in one place today. Being on the Veterans' Committee and the Veterans' Oversight Committee is not one of those glamorous committees that you see portrayed on CSPAN, but I understand, and certainly the chairman understands, how imperative it is, especially at a time like this when we grapple with what we do for our veterans, what is going to happen to those to-be veterans who will be called up to preserve the well-being and safety of this country.

I am a liberal in terms of veterans. I don't think we can do enough for them; they are public safety officers par excellence. But I would like today not to condemn or criticize; the issue today is recovering the cost of medical care from third-party insurers. Every successful private and public hospital in America is able to accomplish this task to a satisfactory level. They recover costs or they go out of business. Here the VA's track record in medical costs recovery is not nearly as strong as its counterparts in the private sector.

Private sector facilities usually rely on their fund collection activities as their principal means of revenue. They generally can't tap into congressional funds, and into congressional appropriated funds, and therefore must do a better job at recouping medical cost. This is an issue that has had significant oversight over the past

few years. Today we have experts from GAO and the VA IG, and the private sector, all testifying on this issue.

In the past we have had numerous groups, some expensive consultants, look into centralized versus decentralized processing and in-house versus contracted-out options. Despite this increased oversight, the MCCF did not show a significant improvement until this fiscal year. Some of this improvement may be due to the effectiveness of VA's reasonable cost billing system. But the VA still falls short of the private sector. Why? The funds recovered using the MCCF act as supplemental appropriations and may be used at the local level to improve health care.

With effective patient registration, medical documentation, treatment coding, billing, and a robust follow-up on outstanding accounts, medical centers and VISN's augment all their appropriated funds. Good management seems to indicate that the VA should maximize the effectiveness of the MCCF.

This on the surface would seem to make sense. On panel 4 we have called a witness, Ms. Karen Sagar of the Martinsburg VA Medical Center in West Virginia, a leader who has been effectively managing her MCCF. Mr. Chairman, we need to find out what is working and get everyone on that band wagon. In Ms. Sagar's written statement she states that she has people in her collections unit, accounts receivable assistants, she calls them. She says they are very persistent, assertive and they will exhaust all means to obtain a valid payment. Each of these people have specific expertise on how to deal with insurance carriers. This may not be the only piece to the puzzle in finding any kind of best practices, but I think it shows the right attitude. I can't wait to hear her testimony. Let us look forward to finding a solution, for all past failures lend little to the argument. I yield back, Mr. Chairman.

[The prepared statement of Congresswoman Carson appears on p. 44.]

Mr. BUYER. Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. In the interests of time, I am going to have a very brief oral statement, and I have a written statement that I ask unanimous consent be made a part of the record.

Mr. Chairman, thank you for holding this hearing. It is a significant issue in spite of the fact that our minds are on other things, and I certainly align myself by statements made by you and the ranking member, including her comment about being a liberal regarding veterans.

Mr. Chairman, we are the Oversight and Investigation Subcommittee, and this is an area that we have talked about last spring when we talked about the budget. You indicated that there are improvements being made. I don't quite understand why we can't lick this particular problem. I mean, there is free money out there. The insurance company premiums are not reduced as a result of the fact that nobody is going after payment from them. So they are getting the premiums and the input is the same but the output, if you will, is not because they are not paying it because the VA is not going after them adequately.

So I commend you, Mr. Chairman, and knowing your bullheadedness, I use that term in a complimentary manner, I think good things are going to come from this area. Thank you, sir.

[The prepared statement of Congressman Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS

Thank you, Mr. Chairman.

Certainly last week's tragic events are at the forefront of everyone's mind. The death and destruction brought about by the attack is unfathomable. There is no doubt that September 11th will long be remembered, and our thoughts and prayers are with those whose lives have been forever altered by this tragedy.

President Bush has urged Americans to resume their lives. And so today, congressional committees across Capitol Hill resume the important work of the people—work that was planned long before our lives were so violently interrupted. Today's hearing certainly focuses on an important topic—the VA's Medical Care Collection Fund (MCCF).

Many years ago, the Congress gave the VA the authority to collect reimbursement from third-party for the treatment of a veteran's non-service-connected condition. In 1997, Congress gave the Department of Veterans Affairs (VA) the authority to retain the third-party collections it recovers. At that time, the VA proposed a 5-year plan under which it would obtain ten percent of its revenue from third-party collections and alternative revenue sources.

Unfortunately, the VA has fallen woefully short of this goal. I understand that revenues from alternative sources will only reach about four percent in fiscal year 2002.

The VA's poor performance in collecting third-party reimbursements has been a concern of this Committee's for some time. In fact, I raised this issue at our budget hearing earlier this year.

One issue that has come to my attention is that collections vary widely throughout the VA's health care system. I am very concerned that Veterans Integrated Service Networks (VISNs) that do a good job collecting from third-parties are penalized for it. I will be exploring this issue later in our hearing.

Again, thank you Mr. Chairman. I look forward to hearing from our witnesses this morning.

Mr. BUYER. Thank you Michael. Mr. Udall.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you, Mr. Chairman. Also just a brief statement, but let me also associate myself with your comments on the September 11 tragedy. I know we all feel a great deal of sorrow today.

Mr. Chairman and Ranking Member Carson, thank you for holding this hearing today about medical care collection funds. I am looking forward to hearing the testimony of our distinguished panel. The MCCF, which was created to allow the VA to seek reimbursement from third-party health insurers for medical care costs for nonservice-connected veterans, has been underperforming since its creation in 1986. Compared to private hospitals, it takes the VA on average 14 times longer to bill. We should be able to do better.

It has recently been shown that some of the MCCF programs have been relatively successful. These include the programs that invested in a capable revenue-generating team rather than seeking funds to simply cover shortfalls.

Therefore, I believe in identifying potential fixes for the MCCF program, we should focus on basic management practices for the MCCF managers and providing better support from their facility leaders. It is my hope that in doing so, we can build on the positive performance from the MCCF in fiscal year 2001 and create better

management practices to create a program that will prove to be consistently successful. By doing so, we can create a program that will allow the VA to maximize the collection of funds for medical care while minimizing the cost. Thank you for the opportunity to speak, and I look forward to working with you and my colleagues on the subcommittee. I yield back.

Mr. BUYER. Thank you. I couldn't help but think before I yield to our first witness, listening to the three statements from, Ms. Carson, Mr. Udall and Mr. Bilirakis, that sometimes we get taken advantage of because of our generosity.

We gave authority to the VA to make these collections, but perhaps it is easier for the VA to come to us and continue to fund their budgets. So perhaps our generosity is getting us in trouble. I would ask for the first witness, Mr. Backhus, to please come forward from the GAO.

STATEMENT OF STEPHEN P. BACKHUS, DIRECTOR OF HEALTH CARE, VA AND MILITARY HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY RONALD J. GUTHRIE, ASSISTANT DIRECTOR OF HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE; AND TERRY J. HANFORD, SENIOR ANALYST, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE

Mr. BUYER. Mr. Backhus, in your hoping, if you would please introduce and identify those whom are with you.

STATEMENT OF STEPHEN P. BACKHUS

Mr. BACKHUS. Gladly. Good morning, Mr. Chairman——

Mr. BUYER. Good morning.

Mr. BACKHUS (continuing). And members of the subcommittee. On my right is Ron Guthrie, and on my left is Terry Hanford. Both are from our office in Denver and conducted the detailed work that leads to this statement. We are very pleased to be here, Mr. Chairman, to discuss VA's continuing efforts to increase collections from private insurers for the medical care it provides to veterans with nonservice-connected conditions.

These third-party collections, as they are called, represent an important source of revenue that VA uses to supplement its medical care appropriations, money that VA can use to provide health services to veterans. In today's environment of increasingly scarce resources, every dollar is important, and therefore VA needs to maximize this revenue source. For many years, we and others have reported on VA's revenue operations, pointed out problems with VA's collection efforts, and recommended ways to increase third party revenue. Today at your request, Mr. Chairman, we are here to update the subcommittee on the status of VA's collections this past year and their progress in pursuing a 1999 business plan to maximize third party revenues.

Our work is based on a survey of all VA medical facilities and networks, discussions with VA headquarters officials, site visits to four facilities and one network, a review of internal VA studies and plans on the topic, and an analysis of private sector operations and benchmarks.

Overall, Mr. Chairman, it appears that for this fiscal year, VA will significantly increase its third-party collections. Revenue is expected to top $500 million, the most ever collected. Obviously, this is very good news. But I need to point out that the increases are likely the result of VA's charging insurers more for the care it provides rather than the result of processing improvements in its revenue operations.

As VA acknowledges in a recently completed report, and it is confirmed by our review, their current revenue operations are deficient in several respects. First, VA does not identify all veterans with private health insurance. Nationally, VA bills insures for only about 16 percent of patients treated——

Mr. BUYER. Would you repeat that?

Mr. BACKHUS. Nationally, VA bills insures for only 16 percent of patients treated, but it is likely that many more veterans have insurance. Documentation of the care provided has also not been sufficient to insure that all care is being billed. A VA contractor estimated that VA could have collected $459 million more this year if physicians' oversight of residents was properly documented. Proper coding of all medical procedures in services for billing is another challenge for VA, in part because of difficulties VA has had maintaining sufficient and proficient coding staff. Limitations in the current billing software causes VA to rely on manual processes. That increases the probability of error and slows production. For example, VA's average lifetime to bill is 74 days for inpatient care and 143 days for outpatient care. By comparison, private sector benchmarks are 5 and 6 days, respectively.

Finally, the majority of VA's accounts receivables exceed 90 days, whereas in the private sector, only 29 percent are this old. Obviously, there is substantial room for improvement in all aspects of the operation of VA. In this regard, Mr. Chairman, you asked us to examine and report the extent to which VA has progressed in implementing its 1999 plan to pilot test alternative approaches for improving revenue operations.

Specifically, VA's plan called for networks to consolidate all or part of their operations and to evaluate the effectiveness of using contractors. While VA has consolidated some processes and is using contractor staff for some activities, these efforts, as currently designed and tested, provide little basis for selecting the best alternative. For example, VA's facilities and networks reported to us that most of their contracts are temporary to meet immediate needs, such as reducing backlogs of claims. Additionally, no network volunteered to extensively contract out. And the one network that was going to use contract for coding, billing, and accounts receivables never found a contractor that was acceptable to them.

As you no doubt are aware, the Secretary of VA recently directed that a new plan for improving revenue operations be developed, and I believe the plan was provided to you yesterday. We reviewed a draft of the plan and have mixed feelings about it. On the one hand, it clearly identifies and recommends many actions that need to be taken, which if implemented properly, will indeed improve operations.

On the other hand, however, we don't think the plan contains sufficient detail or places sufficient emphasis, on how or even

whether these actions will increase net revenues, the key criterion for choosing among alternative actions.

It appears the VA will make significant efforts at improving its in-house operations over the next 2 years; yet the effect that these actions are expected to have on net revenues is not addressed, nor does the plan lay out specific or solid approaches for evaluating options, such as contracting, but the plan instead seems to put off consideration of such alternatives until 2 years from now.

We believe that VA can and should begin now a more thorough comprehensive evaluation of alternatives. But it may take direction from Congress to get it done, perhaps in the form of establishing a demonstration program to test contracting. Such a demonstration, along with VA's ongoing consolidations using in-house staff, its 24 planned improvements and data on net revenues, would better position VA to make a fact-based decision about which approach to take.

Without such an integrated approach, we are afraid that VA will not be able to choose the best alternative for generating the most funds, at the least cost.

Mr. Chairman, this concludes my prepared statement. We will be happy to answer any questions you have

[The prepared statement of Mr. Backhus appears on p. 45.]

Mr. BUYER. How would you foresee a pilot program? What is your vision?

Mr. BACKHUS. If I could draw it up, I would ask that there be a network designated, if one doesn't volunteer, to enlist the support of a contractor in all elements of the process, to bring to bear on this process the innovation and creativity that a contractor might offer. I don't know what the particular specific ideas that a contractor might bring, but what is needed is one of them to step up and offer to come in and see what they can do to make this process more efficient. I am not suggesting here that in the case of information technology an area that really has to be improved in VA, that the contractor have the ability to change the VA IT infrastructure here.

That is an issue that has to be settled in the larger context of the entire VA as they decide and try to design a new architecture system. But a new contractor can try to come in and develop its own interfaces with that, its own way of interacting with the data the VA has, offer any suggestions for potentially what a new IT infrastructure ought to look like, concurrent with establishing their own procedures for the other parts of the process.

Mr. BUYER. I can envision, as we work with the Secretary on that new architecture. I mean, you brought up the three strong areas. You have got the personnel, the IT, and the systems, and they all have to integrate and coordinate. In your written testimony that I read last night, on page 9, you mentioned—this is on the decentralized responsibility to the present challenges—you said "the collection performance varies widely from facility to facility, for example, one facility takes an average of 16 days to send an inpatient bill while another averages 342 days.".

Do you have any idea what the average number of days it takes in the private sector to perform similar tasks on inpatient, outpatient billing?

Mr. BACKHUS. I do. The benchmark for the inpatient and outpatient care billing is 5 and 6 days, respectively.

Mr. BUYER. Five and 6 days.

Mr. BACKHUS. Correct.

Mr. BUYER. You just took my breath away. Ms. Carson.

Ms. CARSON. Thank you, Mr. Chairman. Mr. Backhus, in recovering medical costs, one approach to measuring performance is to measure net revenues as a percentage of total billings for a VHA facility. Is this both a fair and accurate measurement system of MCCF success? What variables impact the reliability of the data? What is the rate of return in the private sector?

Mr. BACKHUS. Net revenues is, we consider to be the single biggest measure of effectiveness in the program. It is absolutely vital that the VA generate the data it needs to compare what it collects with what it costs to collect. At the present time, there is not good information on that; so I have a concern that as the VA proceeds with its implementation plan and talks about how much additional revenue they bring in, that we need to know at the same time what it is costing them to collect. This is all about increasing the net to minimize those costs, to know what those costs are, to get the largest bang for the buck. It is also important to be able to know not just whose net revenue—what is the potential for collection. So it does matter in terms of the size of the facility, who has the most potential or not.

So if you put those two together, what the potential collections are and the net collection amount, those should be good measures of success.

Ms. CARSON. Good. Thank you.

Mr. BUYER. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Mr. Chairman, in your opening statement, you made the comment that collection dollars have increased. And it seemed like that was an improvement, if you will, and yet, Mr. Backhus, you emphasize that an increase in dollars is really due more to the charging the insurance companies more as against better collection process; is that right?

Mr. BACKHUS. Yes, sir.

Mr. BILIRAKIS. We want to make sure we emphasize that in the record. You made a comment too, if I heard you right, that collections would be improved if physicians' oversight of the veteran was properly documented. I think those were the exact words. What do you mean by that?

Mr. BACKHUS. The medical record of the services that were provided to the veteran, the diagnosis, the treatment, needs to be clear in order for an insurer to accept a bill, and it also needs to be clear in order for a coder who translates the clinical information into a set of standard procedure codes which later go to an insurer that they can interpret. It has to be clear. The folks who produced the bill have to see clearly what is in that medical record in order to prepare a proper bill.

In this particular case in VA, the doctors, especially those who supervise residents, the folks—the doctors in training, if there is care that is given by a resident, it has to be in the medical record that it was under the supervision of a physician and it was appropriate in order for the insurance companies to pay, in order for the

people who prepare the bills to bill it. And that is what is missing. There is——

Mr. BILIRAKIS. So you attribute much of the problem to just a lack of proper coding of the bill that goes to the insurance company?

Mr. BACKHUS. Correct. Sufficient information is being left out of the record——

Mr. BILIRAKIS. Somewhere in all this paperwork, I read about an outpatient veteran going into a center and was billed $50, and it turned out that that patient had an MRI, which alone is something like $900 or something like that. I chair the Health Subcommittee of Energy and Commerce Committee, and I get involved with these things. I don't remember reading where that,—but I don't think even the $50 was paid by the insurance company as a matter of fact, but that is an illustration of what you are referring to?

Mr. BACKHUS. It is.

Mr. BILIRAKIS. Wow. So whereas that insurance company should have paid and probably would have paid for the MRI as well as any other outpatient work that was done, the only thing they would require to pay would have been the $50 that they were billed?

Mr. BACKHUS. Correct.

Mr. BILIRAKIS. As I remember they were very reluctant to even pay the $50. This was a discussion I had with Dr. Garthwaite back during the budget process. If private contracting were to take place, whose responsibility is it to make sure, or at least to set up the process, proper billing process, the proper documentation and all that so that these things don't fall through the crack? Should this be made to the VA's responsibility so you can have a uniform type of system?

Mr. BACKHUS. Absolutely. That is the VA's responsibility, and even if they would contract out ultimately they need proper oversight of that process to make sure that the performance is where they needed to be.

Mr. BILIRAKIS. Who would conduct that proper oversight in this network that you mentioned earlier?

Mr. BACKHUS. There is an office within the VA that takes care of all this.

Mr. BILIRAKIS. When it comes to cost to collect, we don't know apparently what it is costing now for the VA to make the meager collections that they are collecting; is that right?

Mr. BACKHUS. That is correct, we do not.

Mr. BILIRAKIS. Would the costs be less if all this were done through private contracting where the private contractors would receive, let's say, a percentage of their collections, and therefore it really would not cost the VA anything? Would they net out better?

Mr. BACKHUS. This is what we need to determine. This is what needs to be tested and proven. I can tell you we did obtain some information on what it costs VA to collect, and it is substantially higher than what we see the private sector benchmarks to be; so the theory is it makes sense there is an opportunity here. But I cannot say at this time that that is necessarily going to be the outcome until it is really tried.

Mr. BILIRAKIS. Thank you, sir, for being here and for the suggestions you made. Thank you, Mr. Chairman.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. You mentioned in, Mr. Backhus, in your testimony, that the VA bill is only 16 percent of the veterans treated. That 16 percent figure, is that nonservice connected, or what is included in that figure?

Mr. BACKHUS. The only insurance from which the VA is entitled to collect is for care for nonservice-connected illnesses or injuries. So not every veteran who presents themselves for care would, even if they had insurance, would be eligible to collect. So the 16 percent represents what approximately right now is only a measure of all the veterans that present themselves. It is not intended to be a measure of the percentage of all the eligible billing. We don't know what that number is. Nobody knows exactly what that number is because the veterans are the ones where more of that information has to come, and if they are not going to volunteer that they have insurance, it is difficult for the VA to find out.

There are opportunities potentially for testing different sources of information as to who has insurance and what for. That is part of what I think needs to be incorporated into a future plan. But now that 16 percent really represents the percentage of all the particular veterans who receive care, who the VA eventually bills an insurance company.

Mr. UDALL. And you could have a fact situation where a veteran presents at a veterans hospital and is service connected, but some of the things they are presenting for nonservice connected that should be billed in this—against the third party, I imagine.

Mr. BACKHUS. That is exactly that situation. It is up to the doctor to make a determination as to whether that particular injury or illness is service connected or not.

Mr. UDALL. And part of your conclusion is the doctors need to be more diligent in terms of these kinds of subtleties.

Mr. BACKHUS. No question about it.

Mr. UDALL. I am interested in the size of the staff that you need in order to recover and what is the optimum size. You could have an MCCF staff of 10, let's say, that could recover X million dollars and then a staff of 25 recovering two X million dollars. What are the considerations in determining optimum size of an MCCF unit, either in-house or on contract?

Mr. BACKHUS. You have really hit on a good point there. I don't think there is, that I am aware, a good benchmark for the VA for what makes the optimal size. Part of the improvement plan that the VA is trying to implement is consolidation. It doesn't make sense necessarily for every facility to be collecting or having all parts of the process. There is efficiency in consolidation, in some cases, in nationalizing some of these processes to be able to do it in one location.

Now some of these are done in 134 locations. That all remains to be determined. That is what needs to be tested. We have to be able to determine and know what effect of all of this is on net revenues. It is not okay to say that we have collected a hundred million more dollars this year without knowing how much more we spent to collect it, without knowing on an individual location-by-location basis how they are each doing. There is a need for accountability and better information so that your very question can be answered.

Mr. UDALL. You are saying we have 134 of these teams around the country?

Mr. BACKHUS. Actually it varies. I mean, some processes are consolidated now, some parts of the process are consolidated now. All parts of the process are not done everywhere, so there would be fewer than that. Actually, it's more than that, isn't it? 139.

Mr. UDALL. 139. So that sounds like a lot to me. Are we—are you recommending that we look seriously and the VA looks seriously at consolidation with those numbers?

Mr. BACKHUS. Absolutely. That is where this goes.

Mr. UDALL. Thank you very much. Thank you, Mr. Chairman.

Mr. BUYER. In your review, has the VA followed its business plan as presented to this subcommittee and Congress in 1999?

Mr. BACKHUS. No.

Mr. BUYER. Your answer?

Mr. BACKHUS. No, sir.

Mr. BUYER. In your statement, and again, I will refer back to page 9, you estimated VA's personnel cost to collect was 24 cents a dollar across the board for inpatient and outpatient bills. Do you know what it is in the private sector?

Mr. BACKHUS. I do have some information on that, though I am uncomfortable with this kind of a comparison.

Mr. BUYER. Let me ask this. Well, I will withdraw my question. How difficult was it for the VA to convert the use of reasonable charges?

Mr. BACKHUS. Very hard. A lot of work was involved. That was quite a lengthy process. I think now that—now they are fairly proficient in most places at it, but I think they underestimated the difficulty, and therefore there were delays and fits and starts, and even, I think initially, collections went down while people were adjusting and learning how to code into the currently used and standard terminology. So there was a lot of effort that had to go into it and very difficult.

Mr. BUYER. I would like to, on behalf of the committee, I would like to thank the GAO, not only you, Mr. Backhus, but your staff, in preparing this report and your testimony to Congress. A lot of hard work went behind this and a lot of good quality work that will be helpful to us as we mover on and proceed.

Mr. BACKHUS. Thank you.

Mr. BUYER. So thank you and I appreciate your being here today.

STATEMENT OF HON. RICHARD GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY MICHAEL SLACHTA, ASSISTANT INSPECTOR GENERAL FOR AUDIT, DEPARTMENT OF VETERANS AFFAIRS

Mr. BUYER. I would like to recognize the Honorable Richard Griffin, the Inspector General of VA, and ask him to introduce his staff that he may have with him and their positions, and then you may proceed with your testimony.

STATEMENT OF HON. RICHARD GRIFFIN

Mr. GRIFFIN. With me this morning is Mr. Michael Slachta, who is the Assistant Inspector General for the Office of Audit.

Mr. Chairman, members of the subcommittee, I am here today to report on our work concerning the Department of Veterans Affairs medical care collection fund. During the past several years, we have reviewed selected VA MCCF issues and have identified opportunities to enhance recoveries.

As you know, in 1998, we issued our audit of the medical care cost recovery program, making recommendations which VHA concurred with. Also, our combined assessment program reviews have identified the following program weaknesses: Facility staffs not effectively determining veterans' eligibility and entitlement status; facility staffs not effectively verifying and coordinating patient care with insurance carriers; medical record documentation of care provided was not adequate; bills were not accurately coded, and bills were not issued in a timely manner; and finally, collection efforts on delinquent accounts were not aggressively pursued.

One recent CAP review disclosed backlogged third-party reimbursement claims valued at $10.5 million. The VAMC could increase MCCF recoveries by about $3.2 million by processing backlogged outpatient bills. My office of health care inspections is reviewing outpatient coding accuracy, data reliability, training initiatives, and implementation of compliance programs. Our review disclosed that the employees need to focus their attention on reducing the coding error rate for outpatient visits and improving their internal control processes. About 50 percent of the 570 outpatient visits reviewed contained coding errors.

My office of audit is conducting an audit of fiscal years 2000 and 2001 MCCF billings and collections. Although collections are increasing in fiscal year 2001, interim audit results show potential for significant additional collections. The following are some of the problems we have identified to date. Timeliness of billing affects the amount collected. Our current audit found that on average, VA took 95 days to bill. Our 1998 audit found a 48-day average billing time, and in calendar year 2000, private industry averaged only 10 days to issue bills. VHA's unbilled care report showed that $931 million had not been billed. We estimate that based on VHA's current collection rate of approximately 34 percent, issuing the bills comprising this backlog could result in additional collections of approximately $317 million.

Our review of randomly sampled cases from fiscal year 2000 patient discharges identified missed billing opportunities because the treatment provided by attending physicians was not adequately documented. Based on the sample, we estimate that VHA missed the opportunity to recover $18 million for inpatient care provided to 47,000 veterans during fiscal year 2000. We also reviewed a random sample of fiscal year 2000 third party inpatient treatment bills. We found that VHA staff did not follow up with insurance carriers on delinquent receivables in 77 percent of the cases which we reviewed.

We estimate that VHA lost the opportunity to collect $117 million by not following up with insurance carriers. Based on our current audit to date, we believe the Under Secretary for health would improve MCCF activities by directing that VISN and VA medical facility directors ensure that billing opportunities are not missed, the backlog of bills is eliminated, and future bills are issued timely;

by communicating MCCF performance goals to VISN and medical center directors as well as clinical and administrative staff and holding them accountable, expanding training for personnel involved in the billing process, by ensuring that VA medical facilities use the preregistration software, and by following up with insurance carriers on delinquent receivables.

By implementing our recommendations, we believe VHA could have increased collections by $135 million in fiscal year 2000. By clearing the backlog of $931 million in unbilled care, VHA could increase current collections by an additional $317 million.

Before closing, I would be like to extend my sincere gratitude to Dr. Garthwaite for his 25 years of dedicated service to our Nation's veterans. Since 1995, while he served as the Under Secretary and Deputy Under Secretary, VA has expanded access to 600,000 additional veterans by extending their coverage through the establishment of 770 ambulatory care and community-based clinics. In recent months VHA has been recognized for its achievements by the New England Journal of Medicine, the American Medical Association, and the Malcolm Baldridge Presidential Award for Quality. I want to congratulate Dr. Garthwaite on these commendations and wish him Godspeed as he concludes a quarter of a century of service to our Nation's veterans.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the subcommittee may have.

Mr. BUYER. Thank you Mr. Griffin.

[The prepared statement of Mr. Griffin appears on p. 61.]

Mr. BUYER. Before I go to the questions, the core of this hearing, I have to ask another question first. The last time we were together with—Ms. Carson and I had a hearing in Indianapolis, and you appeared with Secretary Principi and we had some discussions with the Secretary about the $6 million fraud case in the Atlanta regional office. Are there updates that you could give the subcommittee at this time?

Mr. GRIFFIN. The Secretary has requested that the IG initiate a national review in the area of single one-time large payments in veterans benefits administration. We have searched for the data. There have been approximately $2.8 billion in those payments over the past 5 years, over 54,000 transactions divided amongst the 58 regional offices. Starting next Monday morning, we will have teams of auditors and criminal investigators on site at eight regional offices to begin the process of reviewing all 54,000 of those single, large, one-time payments, which are defined by being more than $25,000.

The activity in Atlanta is proceeding smartly. Current losses now are in excess of $10 million. There will be a number of additional dependants prosecuted in the near future, as the case moves through the judicial system. It is a major undertaking. It is something that has required us to cease doing some of the other audits and combined assessment reviews that we had projected, so that between now and January 1, we can try and get out to all of these regional offices and identify what the true magnitude of the problem might be.

Mr. BUYER. Thank you. You mentioned that the VA's unbilled care report as of July, 2001, shows a cumulative balance of $931 million. Is the balance increasing at a significant rate?

Mr. GRIFFIN. The balance is increasing by about 5 percent a month; so it is increasing by a substantial rate and has been in recent months.

Mr. BUYER. 5 percent a month?

Mr. GRIFFIN. Last month it went up $51 million.

Mr. BUYER. 5 percent a month. 5 percent of a billion is a lot of money.

Mr. GRIFFIN. It grew from $931 million at the end of July to $982 million in the end of August.

Mr. BUYER. All right. When you referred to the term as backlogged billing, define that for me. A backlog in billing, do you include an unbilled charge in backlog of billing, and do you also include that which we have yet been unable to receive? Define for me what——

Mr. GRIFFIN. Backlog in billing is bills that have not been sent out for collection yet.

Mr. BUYER. So if we are to take the unbilled balance of almost a billion dollars, now let us incorporate in that what has been billed but not yet received, and for how long is it sitting out there before we can reign it in?

Mr. GRIFFIN. The evidence shows that the longer one waits to submit a bill, the lower the rate of return. That is why you have seen in the private sector very timely issuance of the bills.

Mr. BUYER. That is not responsive to my question. Do we know an approximate number of how much is being presently billed out there and has not been received? How much is sitting out there?

Mr. GRIFFIN. We do not have a total number for how much has been billed system-wide.

Mr. BUYER. If you go to a particular VA hospital, would they know that answer?

Mr. GRIFFIN. For their particular hospital, they should have that information because they should be pursuing those bills with insurance companies.

Mr. BUYER. How long does it take from when we actually bill to when we actually collect? How long does that take?

Mr. SLACHTA. That will vary by insurance company. We do not have a set figure on how long it takes. I can't give you a figure. I can say it can range up to 6, 7 weeks. But it may be even longer in some places.

Mr. BUYER. If you have an obstinate insurance company out there, how do you go after them? Do you have in-house counsel, or do you have turn to the U.S. Attorney?

Mr. GRIFFIN. The Department has an Office of General Counsel which can be brought to bear. They have regional counsels around the country.

Mr. BUYER. How often does in-house counsel go after an insurance company?

Mr. GRIFFIN. I can't answer that as we sit here.

Mr. BUYER. I bet you have to have a feeling.

Mr. SLACHTA. The last time that we actually looked at the collections were for the general counsel was back in 1998. We have not

looked at it recently. At that time we thought that they needed to be a little more aggressive.

Mr. BUYER. How many lawyers out of the general counsel's office are assigned to the collections of moneys against those insurance carriers? You don't know.

Mr. SLACHTA. Don't know.

Mr. BUYER. So I get to ask the VA when they come up. We are going to give them an opportunity to get that answer, so we will filibuster a little bit.

You know, we are also concerned not only—I can't help but think with my colleagues here that if I was an insurance carrier out there, I would be enthused if I have got one of my beneficiaries that is going to be treated at the VA. You know it.

Let me yield to Ms. Carson now.

Ms. CARSON. Thank you very much.

Mr. Griffin, I would say again what a joy it was to have you in my district in Indianapolis. I hope you enjoyed Indianapolis. You have been doing the MCCF and CAP reviews since March of 1999. And the Inspector General did find weaknesses and make recommendations for corrective actions. What improvements have you noticed during those reviews or those follow-up reviews?

Do medical centers respond to your recommendations by demonstrating a significant improvement in collections a year down the road?

And then quickly, Mr. Chairman, if I can just insert this other question, they can facilitate it.

You notice problems with all key MCCF areas in your testimony. You note a backlog of unbilled care, coding request errors, a lag time, failure to follow up, a lack of preregistration software and other problems. What do you think the maximum MCCF rate of recovery defined as net revenue over MCCF billable care charges should be; for example, 50 percent, 70 percent, 90 percent?

Mr. GRIFFIN. If I can take this in parts. You asked about our CAP reviews and whether we saw positive improvement after the fact.

Ms. CARSON. Yes, sir.

Mr. GRIFFIN. As you mentioned, we started doing these CAP reviews in March of 1999. We have done 45 medical centers to date, and of the 45, based on our findings from our 1988 audit, there were 32 facilities that had one or more problems in their MCCF program.

A problem present at 14 facilities entailed obtaining a signed means test. Nineteen facilities were not billing timely, and 12 facilities needed to be more aggressive in the collection of their bills.

Because this time period coincided with the transition to reasonable expense billing, it was a time of change in these medical centers. We pointed out these recommendations where they are the most problematic.

Our follow-up group will maintain communication with the medical center until we get something in writing to demonstrate that they have put the proper procedures in place.

I can't give you a percentage improvement for any of the centers at this point in time, but we have discovered that in almost three

out of four facilities that we have been to in the last 2 years, there are continuing problems.

Ms. CARSON. It would help then if you had more IGs who could facilitate this review process so that the committee could better understand more quickly where the VA stands in terms of these?

Mr. GRIFFIN. There is a lot of demand for our resources. At this point we are going to have to suspend this MCFF Audit for the next 3 months in view of the current national VBA review that we are undertaking.

So, as you know, we feel strongly that we could use some additional resources, as the Chairman knows also.

Ms. CARSON. Thank you very much.

Mr. BUYER. You know, I mean, this is the second time Ms. Carson has spoken as a true advocate for the IG, so I have gotten the message.

Mr. Bilirakis.

Mr. BILIRAKIS. Mr. Griffin, you prepared this testimony and this report for the purpose of presenting it before this committee. I guess my question goes to, does the IG on a routine basis audit and prepare similar type reports?

Mr. GRIFFIN. Yes. The reason we are doing a full audit of this program today is because the findings in our 1998 audit, which was published in July of 1998.

We understand that this is a huge problem, and there is a lot of revenue that could be coming into the Department. So we decided that after 2½ years we need to go back and do another full audit and see how the program was progressing.

Mr. BILIRAKIS. So you would have done that even if you weren't invited?

Mr. GRIFFIN. Right. And because it is such an important issue, we have made it one of the items that we look at during all of our combined assessment reviews, which are 1-week visits to medical centers to try to hit those things where we think are systemic problems.

Mr. BILIRAKIS. Well, it may not be directly part of this hearing or this issue, but let me ask you, you concentrated strictly on third-party payers for the purposes, or do you also look into first-party payers, the copayments?

Mr. GRIFFIN. We looked at both.

Mr. BILIRAKIS. You looked at both.

Mr. GRIFFIN. Yes, sir.

Mr. BILIRAKIS. What has been the collection history regarding first-party payers?

Mr. SLACHTA. The percentage of first-party collections have been increasing.

Mr. BILIRAKIS. All right. Is that because of the—there is no question of billing problems, is there, with first-party payers? It is just as—there is copayment.

Mr. SLACHTA. It is the same thing.

Mr. BILIRAKIS. Well, if it has been better as far as first-party payers are concerned, meaning the veteran, is it because the VA has been more aggressive in going after the veteran than they have after the insurance company?

Mr. GRIFFIN. I think part of the answer is that the number of veterans receiving treatment in VHA facilities has increased over the past several years, so you would expect an accompanying increase.

Mr. BILIRAKIS. So we are talking, again, the same sort of thing where with insurance companies, the—the building—the amounts have gone up—the charges have gone up, and therefore that is why the total amount has increased. And with the veteran we are talking about more veterans, so we don't really have better efficiency as far as the veterans are concerned, and I hate to say that, because frankly we are letting all of these insurance companies, the fat cats out there, without going after them, and we are going after the veteran. There is something wrong with all of that, quite frankly.

Mr. GRIFFIN. Right. And again, part of the problem is that our 1998 audit showed a billing delay of 48 days. The current audit is showing 95 days. So it is taking twice as long.

Mr. BILIRAKIS. So it is taking just as long to bill the veteran for the copayment.

Mr. GRIFFIN. For the third party.

Mr. BILIRAKIS. How about the copayment on the part of the veteran?

Mr. SLACHTA. No, that is—well, it is taking as long, yes.

Mr. BILIRAKIS. Let me ask a bottom-line question here. You have furnished us with an awful lot of facts, and we got a lot of facts from the GAO, too, but they furnished us some suggestions on how we can maybe improve this.

My son is a physician, and I know what he and so many other doctors go through on the outside in as far as coding and so far as billing is concerned, and the proper documentation, things of that nature. Now, granted, if they make the same mistakes, they are that much more delayed in lack of reimbursements coming in, so they have a little more motivation to make it right, moreso than the veterans people are concerned, the medical personnel.

But, let me ask you, why? Big question. Why? One-word question. Why do we have these problems regarding the documentation and proper documentation of a 43 percent error rate that you referred to in your statement and things of that nature in the VA? I mean, can you be candid and honest? Why?

Mr. GRIFFIN. I would say there is not a simple answer to the question. There are a number of things here. I think, as was expressed by the Chairman in his opening remarks, there wasn't always a sense of urgency to ensure that these billings occurred for a great number of people. Certainly for the doctors and the other health care professionals it is a collateral duty.

Mr. BILIRAKIS. As it is for the private physician.

Mr. GRIFFIN. Exactly. And in VA—they haven't been held accountable for making sure it happened. But you can't discount the fact that in addition to 173 medical centers, you are also doing billing for several hundred outpatient clinics. And to get everybody in the system up to speed and trained when you make the shift to a new method of billing requires some time.

It is improving now, but certainly there is a lot of room for improvement.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Mr. Griffin, your testimony doesn't really address the issue of in-house or contracted-out MCCF programs. How would you set up, or what would your recommendation be on the MCCF program with regard to in-house or contract support?

Mr. GRIFFIN. We have not looked at contracting as part of our audit. Certainly a pilot project may provide helpful information as to whether that is the way to go. But we have not analyzed the small amount of testing that has occurred to date in the Department.

Mr. UDALL. You don't know whether you would recommend more centralization or decentralized operations?

Mr. GRIFFIN. The fact is that, as was expressed by the previous panel, in order to generate a bill, you have got to get right down to the least common denominator. The doctor must document the care provided and a properly coded bill must be submitted in a timely manner.

Even before all of that, VHA facilities should get insurance information in advance from veterans, not when they present for health care. It is a less stressful time. Tell the veterans, VA needs to have this data to prepare bills for insurance companies and that the Department in previous years has recovered $500 million. How many doctors and nurses can you hire and how much medical equipment can you buy with $500 million.

Veterans should not feel threatened by the concept, they should embrace it because it costs them nothing additional. Their insurance companies are the ones that should be paying for their care.

Mr. UDALL. Your testimony talks about the high rate of coding errors, and it was just mentioned in some of the questions, this 43 percent for outpatient visit records you reviewed. Are these minor or major errors? What is the average dollar value of each error?

Mr. GRIFFIN. I will ask Mike to come up with the dollar value, but I can tell you that two-thirds of the coding errors reflected overcharging, and one-third reflected undercharging. So it is not that all of the errors represent a net gain in revenue, because, in fact, for some of the ones that we looked at they had overcharged the insurance companies. It is then incumbent upon VA to correct these overcharges. There was a case a couple of years ago in California where a Medigap company was significantly overbilled, and a substantial amount of money was rebated to them to make it right.

So it is not a question that it is all on the down side. Two-thirds of the coding errors that my health care people looked at were actually overcharges.

Mr. UDALL. How do we get to that, the over two-thirds of them are being—are overcharge errors? What is the reason behind that?

Mr. GRIFFIN. This is primarily due to coding errors by people who are tasked with preparing a bill for the insurance company. And as was suggested, if the coders can't decipher what is on the medical record then they need to get back with the doctor and get it clarified. You don't just take a guess and send it forward.

So when you talk about whether a private company might do a better job, it still comes down again to the least common denominator of the doctor and the patient and documenting what was done.

Mr. UDALL. And so one—I would assume one of your recommendations would be better cooperation between the doctor and the people that are actually doing the coding and then doing the billing?

Mr. GRIFFIN. That is right.

Mr. UDALL. Go ahead.

Mr. SLACHTA. I am going to have to provide that for the record. I don't have the dollar figures here with me.

(Subsequently, the Department of Veterans Affairs provided the following information)

DEPARTMENT OF VETERANS AFFAIRS,
INSPECTOR GENERAL,
Washington, DC, October 12, 2001.

The Honorable TOM UDALL,
House of Representatives, Washington, DC.

DEAR CONGRESSMAN UDALL: This is in response to the question you raised at the September 20, 2001, Medical Care Collection Fund hearing. Your question concerned my office's review of outpatient billings, and the cost of over and under-billings as a result of miscoding outpatient visits.

My Office of Healthcare Inspections reviewed outpatient coding accuracy and the adequacy of documentation clinicians were providing coders to initiate billings. The review was performed at 15 Veterans Affairs medical facilities during our Combined Assessment Program (CAP) reviews in the first two quarters of fiscal year (FY) 2001.

We reviewed the accuracy of Current Procedural Terminology (CPT) codes assigned to outpatient visits based on the medical record documentation, and we discussed each exception with facility coders. The focus of the review was to test the accuracy of coding and clinical documentation to enable coders to accurately bill for services. The clinic patient records reviewed were randomly selected from data retained at the VA's Austin Automation Center (AAC). The visits had been assigned 1 of 10 Evaluation and Management (E&M) codes in 2 CPT code series. We tested 5 codes for new patient visits (99201–99205) in primary care clinics, and 5 codes for established patient visits (99211–99215) in primary care orthopedics, and urology clinics. The scope was limited to 2 of the more than 100 CPT code series.

Inspectors found that medical record documentation did not consistently support the CPT codes assigned, which resulted in the VA overcharging or undercharging for services rendered. For the 348 billable visits we reviewed, 150 billings (43 percent) were in error. Of these visits, 101 (67 percent) were up-coded, while 49 (33 percent) were down-coded. Third-party payers had reimbursed some of these bills at the incorrect rates. Managers assured us that they would contact the insurance companies involved and make the necessary adjustments.

We were not able to project the national monetary impact of these error rates because of the significant disparities between the billings and CPT code data in the AAC database versus the data maintained in the medical facilities' databases.

A significant number of clinic visits that were reflected as having been billed in the AAC database were in fact subsequently cancelled or changed to different codes after review by facility coders. We found similar disparities between the AAC database and the databases at all 15 sites. Managers told us that they performed retrospective reviews of billable visits and corrected some codes. They also told us that coding corrections must be entered into one database, while corrections that involved billing must be entered into a different database. Entering the corrected codes into both databases was a low priority for medical facility managers, leading to the significant differences in what should have been parallel information.

Because the data were not reliable, our report focused on the accuracy rates rather than dollar amounts, which we believed would provide managers material indications of the efforts that employees were making to accurately document and process outpatient treatments and billings. We found that primary care clinicians needed additional training to better document visits, and to work more closely with coders to improve billing accuracy. The visits we reviewed were relatively low cost, ranging from $45 to $175 each. However, they are high volume, and small dollar differences

due to slight increases or decreases in codes could translate to significant dollar amounts system-wide. To illustrate, during FY 2000, VA reported outpatient-billing collections of $155 million.

We repeated our evaluation during a July 2001 CAP review to test whether processes had improved. We asked the facility to provide a report of all billable visits and revenues in the 10 codes for the 2nd quarter, FY 2001, and tracked each billing to its conclusion. At this site, we took additional time to track down all billings to their source documents and validated each billing amount. This was done because of the limited success we experienced during our earlier CAP reviews in tracking changes in billing data. At this one site, we estimated that, over the course of FY 2001, approximately $40,000 would have to be repaid to insurance companies to correct the up-coding errors, and approximately $12,000 was lost in revenue due to down-coding errors in just the 10 reviewed codes processed.

My office is continuing reviews in this area and we will provide the Committee future reports on this subject matter. If you have any additional questions, my staff or I will be available to discuss them with you. Thank you for your continued interest in veterans and the Department of Veterans Affairs.

Sincerely,

RICHARD J. GRIFFIN,
Inspector General

Mr. UDALL. Thank you very much.

Mr. BILIRAKIS. Would the gentleman yield?

Mr. UDALL. Yes.

Mr. BILIRAKIS. Do you have an opinion whether the insurance companies, at least to some degree, might be using this inaccurate—the error, the inaccurate coding and all of that, as rationale to not make the payments either at all or to delay the payments, you know, cash-flow-type things? I mean, we hear a lot of stories like that in general. Do you have—do you really think——

Mr. GRIFFIN. I would be speculating on that, but, as our report reflects, in 77 percent of the cases we looked at, there was no follow-up whatsoever. Insurance companies might get to the point where they say, well, we have got this bill, but we know we will never hear from them again.

Mr. BILIRAKIS. No follow-up on the part of the VA. I just wanted to be sure that the insurance companies are not sort of taking the VA for a ride because of, you know, the nature of the—of the problem, that sort of thing.

Thank you.

Mr. BUYER. You know, Mr. Bilirakis, Mr. Udall, what you are touching on here on the coding, in 1998, Mr. Griffin, you reported that the coding error rate was 93 percent. 93 percent. Has it improved any?

Mr. GRIFFIN. It has improved. It is not a number you want to brag about. My health care inspectors found a 50 percent coding error over the past several months during their visits to various medical centers.

Mr. BUYER. So your report and findings of 1998, how does that compare to the present work that you are doing right now? Are you in the process of redundancy?

Mr. GRIFFIN. We are finding that a number of the recommendations that we had made in 1998 are recommendations that we will be repeating in our final report, which is still in the process of being drafted. One recurring theme is a lack of accountability. The medical center director, the clinical staff, the caregiver who has to write down the treatment provided, and the administrative staff,

all of these people have to understand how the process works, and they need to be held accountable when it doesn't happen.

That was a recommendation from 1998, and that certainly will be in our report when it is issued for the 2001 audit. Certainly timeliness of billing is another item that was subpart in 1998, and that will also appear in the current audit findings.

Mr. BUYER. Then what you are saying is that—well, this is my own opinion, but it is corroboration of the GAO's testimony that the VA has not even followed its own business plan. That is my own statement. That is not meant for you to respond to.

The last thing you commented on, I think it was to Mr. Udall, in response to him, you said, well, they don't bill service-connected. But if you have a 93 percent error rate, the problem is in our service. Sometimes we have to do a constituent service for a person who has a service-connected disability and who is upset because he got a bill. That is occurring out there, isn't it?

Mr. SLACHTA. Yes, sir. That is occurring.

Mr. BUYER. I don't have any other questions at this time. Does anybody? All right.

Hopefully, Mr. Griffin, as you are doing this grand review, you will also address the last thing we also brought up that is extremely sensitive to those service-connected disabled veterans when you start billing them. Thank you.

Mr. GRIFFIN. You are welcome.

Mr. BUYER. We would like to now recognize our third panel. Mr. Jim Woys. Mr. Jim Woys is the chief operating officer of Health Net Federal Services. And Mr. Edward Gaskell is president of AdvanceMed Corporation.

I would like for them to introduce any staff that they may have with them. And we will proceed under the 5-minute rule. Your written testimony will be submitted for the record.

And I yield to Mr. Woys. You are recognized.

STATEMENTS OF JAMES E. WOYS, PRESIDENT AND CHIEF OPERATING OFFICER, HEALTH NET FEDERAL SERVICES; AND EDWARD GASKELL, PRESIDENT, ADVANCEMED CORPORATION, ACCOMPANIED BY MARIA CASCHETTA, SENIOR VICE PRESIDENT, FEDERAL HEALTHCARE MANAGEMENT SERVICES DIVISION, ADVANCEMED CORPORATION

STATEMENT OF JAMES E. WOYS

Mr. WOYS. Good morning, Mr. Chairman, Ms. Carson, other members of the subcommittee. I am pleased to be here today to address the committee on commercial and TRICARE practices employed in the health care industry with regard to coordination of benefits between insurance companies, plan sponsors and payers when a patient is insured by more than the one company.

I am Jim Woys, president and chief operating office, as the Chairman said, of Health Net Federal Services, a division of Health Net, Incorporated. Health Net is one of the top five management care companies in the Nation with over 11,000 employees servicing approximately 6 million individuals in a full line of medical, dental and behavioral health insurance and HMO products.

Health Net Federal Services currently holds three TRICARE contracts as well as 11 VA contracts across the country. I am responsible for the administration and servicing of over 2 million beneficiaries who depend on the Federal Government for their health care benefits. More than 2,900 dedicated employees of my company and our subcontracting companies bring their collective commercial experience to the government under these contracts.

There are significant dollars involved in the management of the health plan benefits for plan sponsors, including government-sponsored programs. Savings in health care costs associated with the coordination of benefits among carriers can range from 3 to 6 percent of total health care costs. Additionally, since 85 percent of our Nation has health insurance under at least one health plan, and many people are covered by more than one plan, the opportunity for avoiding overpayment of claims through coordination of benefits is immense.

The opportunity for financial recovery is too great to ignore for health insurance companies and other sponsors of the health programs who must be fiscally responsible for limited resources and the high demands placed upon the health care system.

Effective health care program administrators include a disciplined approach to ensuring overpayments are avoided when an individual has more than one form of coverage, and when overpayments occur, they are quickly and effectively recovered. As Ms. Carson stated, it is what we do in the health insurance industry. We go out of business if we don't pay attention to other health insurance, the coordination of benefits.

The three principal activities involved in optimizing coordination of benefits with other health insurance coverages are, first, strong identification. Identify the existence of other health insurance information for the covered beneficiary. Two, enforcement. Enforce the coordination of benefit rules written in the policy of the various health insurance companies. And, third, recovery of overpayments, or accurate billing and coding for services and appropriate recovery of overpayments, or identification of evidence of other health insurance coverage.

The first and most fundamental principle in managing coordination of benefits in our business is the accurate identification and recording of information concerning the individual's insurance or entitlement coverage. To be successful, this has to be an aggressive and continuous information-gathering effort by the entire organization or the health insurer or provider.

The key to timely and accurate identification of other health insurance is gathering information at every opportunity and collecting it in a centralized database environment that everyone can utilize as a single source for enforcing the collections effort in claims and billing administration.

Once other health insurance information has been collected and validated, action must be taken to enforce each insurer's coordination of benefits or third-party liability rules and process accurate billing and collection activities.

As I previously mentioned, my company manages three regional TRICARE contracts for the Department of Defense. Our coordination of benefits activities, called other health insurance or double

coverage by statute, are similar in many ways to commercial practices, but are also different in some very important areas.

In support of our TRICARE program, like in commercial programs, we use the following tools to identify other health insurance coverage: At the enrollment or registration process, provider-supplied information on medical claims, other health insurance questionnaires, requests for referrals and authorizations for care, and any other service contact with our beneficiaries either by telephone or face to face.

To increase the effectiveness, we also utilize several additional tools to find OHI coverage in claims audits, both prepayment and postpayment, newsletters, publications to our beneficiaries, credit balance recovery projects with our providers, investigations for fraud and abuse, and DRJ retrospective validation reviews.

The largest difference between the TRICARE program and the commercial coordination of benefits rules is that TRICARE is statutorily determined to be secondary in coverage with a few notable exceptions, such as Medicaid, TRICARE supplemental plans and Indian Health Care.

I would also like to briefly mention program opportunities in the area of third-party liability claims or subrogation. In many cases, both commercial insurance plans and TRICARE plans pay claims submitted for their beneficiaries even though the responsibility for the ultimate payment rests elsewhere. These payments are made to ensure that our customers receive medical care at the time it is needed for the injuries resulting from auto accidents, work-related injuries or other accidents. These payments, identified as third-party liability claims, are the responsibility of companies providing auto insurance, worker's compensation or liability policies, and efforts to recover third-party liability payments are instigated after a patient has been treated.

State and Federal laws and regulations as well as terms in the various insurance policies determine the collectibility of these claims. Commercial insurers and the TRICARE program devote significant efforts to understanding the rules and regulations guiding third-party liability recoveries, identifying those claims which are truly third-party claims, and recovering the third-party payments made to the responsible insurance company.

In summary, there are several issues that need to be addressed by a health-plan-sponsoring company or government agency if they wish to maximize their coordination of benefit savings and third-party liability recoveries: One, knowledge of the rules; knowledge of the regulations; institute business processes institutionwide to identify potential coordination of benefits and third-party liability opportunities; maintain timely and accurate integrated databases; decide on in-house administration or external administration; link all health plan operations to the effort; educate. There must be an extensive and consistent effort to educate internal staff, health plan providers, as well as beneficiaries themselves.

I have addressed many elements that contribute to a successful program for third-party or other health care insurance collections. In review of these points, information collection is the fundamental element for building and maintaining effective recovery programs.

There has to be a disciplined approach to collecting that information wherever administrative interactions occur with the covered beneficiary or the provider of care. It is essential that the health program administrative processes and data storage elements support this effort in a systematic way.

Again, thank you for opportunity to give my testimony.

[The prepared statement of Mr. Woys appears on p. 67.]

Mr. BUYER. Thank you, Mr. Woys. Mr. Gaskell.

STATEMENT OF EDWARD GASKELL

Mr. GASKELL. Thank you, Mr. Chairman and members of the subcommittee. We thank you for inviting AdvanceMed Corporation. We thank the committee to express our views, specifically an approach the VA may want to consider in its financial management of third-party collections.

I am accompanied today by Maria Caschetta, senior vice president for the Federal Healthcare Management Systems. Our organization provides a wide range of coding services to hospitals and health care systems on a national basis, including the Veterans' Administration.

We are known for success in the Federal Government with regard to starting up, managing high-risk, centralized programs which call for large-scale production operations. These programs involve abstracting, coding clinical data; validating clinical diagnosis, procedures that are coded to bill for—by providers; medically reviewing coded services submitted on claims and their supporting medical record documentation; handling large quantities of medical records in secured facilities; and developing the infrastructure for working with medical facilities, peer review organizations, payer organizations, including electronic tracking systems that ensure accountability for medical record location, status of workloads.

These centralized programs consolidate highly skilled and specialized health care information and technology services and resources. These services help the common needs of multiple and remote user organizations. They generate measures of the work performance through implementation of standard internal quality assurance programs developed by our company. And one of those contracts called for AdvanceMed to function as an independent review entity responsible for generating the data that the government can use to evaluate systems, contractor, and program performance.

The lessons that we have learned from these programs should give some insight into solutions that may be helpful to the VA facing the challenges of getting records coded for subsequent billing and revenue collection.

I would like to state that a major problem we believe facing the VA, as well as this industry, that was touched upon is the shortage—and I am emphasizing—of qualified expert coders. The shortage of coders is compounded by the following: Coders tend to develop expertise in certain types of coding. They work extensively or exclusively on certain types of patients, inpatient, outpatient, for example, specialize in types of coding in clinical specialties required of the specific provider who employs them.

The complexities in the medical documentation coupled with the diversity of coverage and reimbursement requirements by fiscal

intermediaries, carriers and government agencies make it expressly challenging for qualified and educated coders.

And finally, low salaries offered by hospital and government systems coupled with environmental issues results in an unstable coding work force. Further, the VA has unique features and requirements that do not permit wholesale adoption of existing private sector strategies to accomplish coding. For example, designation and exemption from billing of conditions and treatments that are connected to military service liability.

VA physicians, because they do not receive professional fee reimbursements, are often not aware of the importance of proper coding or incentives to perform the required documentation.

VA resident trainees enjoy the benefit of learning from unpaid or shared faculties from affiliates; however, this means that such attending physicians are not compensated by the VA.

VA is responsible for coding that derives from institutional and professional fee reimbursements, and certain VA facilities get professional support from other hospitals, such as telemedicine services.

AdvanceMed believes that the Veterans Administration may benefit from centralized approaches to handling, one, coding functions, and, two, evaluation of services provided by centers that may be set up for this service. The following should be considered when establishing such resources: Implementing national and regional contracts with companies expert in providing coded services and handling large-scale production operations in support of decentralized stakeholders; implementing tracking systems to ensure proper accountability for medical records and workload at all times; implementing standards and requirements for the significant workload processes, production, timeliness of turnaround, quality, training programs and currency of work products, staff certification.

Require ISO registration within 1 year of contract implementation. This will give confidence to the VA that for—that contractors managing and staffing large-scale coding operations have the required standards, systems, policies and procedures documented and in place for running and sustaining a successful high-risk operation.

Require implementing a comprehensive quality assurance program which reports on metrics and corrective action.

Retain control within the Veterans' Administration health information management area for evaluation of the quality of coding provided by centralized or regional contractors. Small samples can be drawn continuously or on a schedule. Qualified hospital personnel could verify the coding done in the sample. Where there are disagreements, discuss them with the coding contractors, come to a consensus, determine error rates and related findings for corrective action.

Prioritize use of centralized coding resources, first for work subject to third-party collection.

Establish a system where initial records are printed, for electronic sources, copied, for hard-copy sources, packaged using standardized approaches, sent to contractors for coding. Consider implementing online access to records where there are—completely elec-

tronic documentation exists concurrently with security requirements that withstand the latest HIPAA regulations.

Require the coding contractor to report back on items that it cannot or should not code.

We have further recommendations that are contained in my written statement.

AdvanceMed appreciates the subcommittee's invitation to testify today, and we thank you, and we are ready to help you answer any questions that you may have.

[The prepared statement of Mr. Gaskell appears on p. 76.]

Mr. BUYER. I would like to thank both of you for the time that you put into your written testimony, and it is very insightful. It will be very helpful to us. And you are absolutely right, Mr. Gaskell. Our doctors don't have that incentive to pay as close attention because they are not having to pay for that staff and pay the mortgage on the building and focusing on the coding and those who are responsible to make sure those trigger mechanisms to get all of this going. And there is a failure in our system on that, and if you have that failure, there is no profit. There are no bills. But your insights are valuable to us. Ms. Carson.

Ms. CARSON. Thank you very much.

There are some similarities between TRICARE and VA health care entitlements in that both, as government health care plans, are secondary to other health insurance for payments. TRICARE seems more successful in recovering payment from other health care insurance than does the VA through the MCCF. What is the average net collection rate from total billings to other health care insurers under TRICARE, and do you think that the net collections rate may be a good benchmark for the VA? If not, why?

Mr. WOYS. Let me clarify first. I am not sure that DOD is any worse or any better than the VA. DOD has the same general direct care system, their brick and mortar, their hospitals, clinics and facilities. They have an information system very similar, I believe, to what the VA has. It was not built upon the VA billing system to capture the data to do proper billing.

So DOD, when patients enter into the DOD system not on the civilian side, but in the brick and mortar, their base hospitals, they have as many problems as the VA does for billing and collecting for these services as the VA does.

We have a much larger proportion of our care than that delivered into the civilian sector—than what the VA has, which is contracted out to major contractors like ourselves, who, again, are at risk for that health care dollar to apply the appropriate resources necessary to try to recover those other health insurance dollars.

With respect to numbers, again, the populations are a little different, so it is hard to do a comparison. But the Active Duty dependents have very small other health insurance. They are lower down on the economic scale, and the Active Duty personnel normally don't have other jobs or other health insurance.

The retiree population under 65 normally have other jobs, and so the presence of other health insurance is very high in that population, and we work very hard to, again, identify who has got other health insurance and work those collections.

But we are in the close to 40, 45 percent range of people who have other health insurance in the DOD environment for retirees. The Active Duty is around 1 percent.

Ms. CARSON. Thank you, sir.

Mr. BUYER. Mr. Bilirakis.

Mr. BILIRAKIS. Just very briefly, Mr. Chairman.

Mr. Woys and Gaskell, are you competitors?

Mr. GASKELL. No, we are not.

Mr. BILIRAKIS. All right. Since we have heard from the GAO that it takes the VA anywhere from 16 to 342 days to finalize and send out an inpatient bill; and then, of course, we have heard about these coding problems and lack of adequate information and everything else, so it takes an eternity to send out the bill; and then, of, course by the time ultimately, if ever, it is kind of agreed upon between the VA and the insurer, that in terms of what the bill should consist of because of coding errors and lack of information, lack of documentation, so you add those particular days on top of how long it took to send out the bill, so, God, we can see the problem that we have here.

If you all did the—on some sort of an arrangement, if you all did the collecting on the part of the VA, how much money would you bring in that is not brought in now?

Mr. GASKELL. Well, we are not doing the collecting. Our company is not on the collection end of this process. We are in the coding end of it and turn it to the collection.

Mr. BILIRAKIS. So you don't do any collecting at all?

Mr. GASKELL. No, just processing and the correction on the coding work itself.

Mr. WOYS. That would be hard to say. One, I think the—the process is one of a culture for any organization, is that it has to start, as have you heard in testimony from the provider, doing the proper medical records, the proper coding, the proper identification at all elements of the organization of who has got other health insurance. And so, you know, to come through and just take a piece, it would probably be irresponsible until you get a big part of the collection that you can make that better.

I would like to make one point that I heard as previous testimony was being given. When—I don't the think insurers would take the concept of and say the VA is treated differently than anybody else with regard to how the claim is submitted.

It sounds like—and I do have some experience with receiving medical claims from the VA. In our TRICARE program we do have VA facilities who are part of our TRICARE network, and we receive claims. We have had, in history, billing problems with them. And if it is—processed probably with other people. And so that inaccurate billing causes insurers to send the claims back.

The other thing is if you get clean claims, most States now, as in the TRICARE program, will pay interest for any claim that is over 30 days. And so I would push the VA to maybe enforce the interest collection of those claims as well if you get clean claims. So it goes back to the first concepts of getting a good clean claim properly coded to the insurer that he can pay timely, because I think the last thing they want to do is pay interest on claims.

Mr. BILIRAKIS. Thank you.

Thank you, Mr. Chairman.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you.

Mr. Gaskell, you recommend in your testimony that the VHA implement national or regional contracts with companies expert in providing coding services and handling large-scale production operations in support of decentralized stakeholders. Assume a national contract that you envision in your testimony. What would you predict would be the gross rate of collections for VHA from billings of other health care insurers?

Mr. GASKELL. I would like to refer that statement to Maria Caschetta.

Ms. CASCHETTA. Yes. I would think that there are two issues here. One is the coding that is required up front in order to get that information to someone who has to bill it. And then secondly, it is the activity to actually complete the bill and get it out the door.

With respect to the coding, any medical record that would get processed and sent to that center would be turned around within 72 hours to 5 days if you are having extreme high volume issues. Generally—we are working with VA hospitals now, and we work with private sector facilities, and in those—in those instances when we get records, we have to turn them around right away.

So having a large-scale production operation really changes the—the paradigm of how coding would get done. There is no other system out there that sends things to one place.

And the VA faces an interesting challenge in that they have to code all kinds of care that is being delivered both professional fee and inpatient care, the institutional side plus the outpatient and the private sector. Those are done by independent providers, and they are done in a distributed fashion.

So it is really a unique challenge, and it is one that I think could be handled very efficiently if you take those core technical—those core technical functions that are extremely difficult to staff in the health care industry and you consolidate them. You will need fewer resources to do the work as opposed to when it is decentralized, plus it gives the system a focus of concentrated skilled resources.

Mr. UDALL. Would you be able to make any projection on the gross rate of collections if—if you did it in this manner?

Ms. CASCHETTA. Well, I would say that we can't predict what they will collect on the tail end, but I would think if the coding was done and prepared and interfaced into the bill, then it is a matter of finalizing the bill and putting it out the door.

And I don't think that—think that having that piece of it solved would greatly contribute to the collection efforts. I think there are people within the system who are, you know, experimenting with that presently, but I can't give a number. I can't project a number.

Mr. UDALL. How would a centralizing coding and collection effort cope with problems in documenting patient care?

Ms. CASCHETTA. Well, typically the type of documentation problems are twofold. There is one that care that was delivered isn't recorded. That is one. And the other type is care is delivered, but the—the party who you need to have sign off hasn't signed off on that core care.

And that is a large part of the dilemma is the latter, that when you have residents providing certain types of care, and the attending physicians don't write their own notes, the VA is following Medicare guidelines for what they will bill, because they are being conservative in that approach, and that you really should have the attending sign off or the attending write their own notes.

So there is certain types of care that you can't just bill, you cannot code and bill for if the documentation isn't there. But if you just took what is there, and you coded it and billed, you would be—you would be moving that much further along. So it is centralized in the—what they would do. Now, the guidelines—and they would document areas where they could have billed had something been different and return that information so that the corrective actions could be more pointed and more specific.

Mr. UDALL. Thank you.

Mr. BUYER. I would be interested in both of you gentlemen providing a written opinion of the VHA's revenue cycle report. I think it would be very helpful to the committee if you were to do that. You don't have to, but it would be extremely helpful to us.

And, Ms. Carson, your question about the TRICARE with Mr. Woys, the reason we have asked him to come here is we have had a working history with many different TRICARE contractors.

(See p. 157.)

Mr. BUYER. When I had oversight over the military health delivery system, we have tried to bring efficiencies to those systems, but I think he is correct. We like to compare different government agencies at times to see how we are doing, and we shouldn't be comparing our collections to TRICARE. Sometimes we compare ourselves, as she just testified, to Medicare at times. It is unbelievable. We think that—we are comparing ourselves to Medicare as a good system, but that shows how abysmal we are, truly.

Mr. Woys, I appreciate your help, and, Mr. Gaskell, you bring terrific insight to this as we try to bring efficiencies to government operations. And I think at the end of this, it almost goes without saying that best business practices come from institutions that are at risk.

Thank you for your testimony.

Next we recognize Mr. Garthwaite, Under Secretary of Health for the Department of Veterans Affairs. Also introduce the staff that you have with you.

Also please be on notice that we may have a vote coming up here shortly on suspension. We will try to go as quickly as we can, in the end maybe say wrap it up.

STATEMENT OF THOMAS L. GARTHWAITE, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JIMMY NORRIS, CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION; DON PRATT, ACTING ASSOCIATE CHIEF FINANCIAL OFFICER FOR REVENUE, VETERANS HEALTH ADMINISTRATION; AND KAREN SAGAR, MCCF DIRECTOR, MARTINSBURG VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION

Dr. GARTHWAITE. It is a pleasure to be here. With me today are Jimmy Norris, our chief financial officer; Don Pratt, our associate

chief financial officer for revenue; and Karen Sager, who is here at the invitation of the committee, but is our MCCF director in Martinsburg, and who has some innovative practices that she has put into place.

My full written statement has been submitted. I really don't have a formal oral statement, but I want to try to make a couple of points in regard to the discussion as has preceded so far.

First of all, I offer no excuses for the fact that we can do better in MCCF, and our current revenue plan and a series of actions that we have been taking are all designed to maximum the number of dollars that we collect and put those to work for veterans.

I would note that it is my belief that not only have reasonable charges helped yield $200 additional million this year, compared to 2 years ago, but that we have put into place a significant amount of effort in compliance, which speaks to the heart of we have to do to have the documentation support the bill we send.

It is my understanding that coding accuracy, which for us be hovering around 50 percent, runs around 43 percent in the private sector. It is not a thing that anyone does exceptionally well. It is a challenge for all of health care.

A couple of comments. There is a management maxim that a system is perfectly designed to gets the results that it gets. Let me tell you what I think a couple of the key issues are that underlie why we are getting the results that we are getting.

First of all, the patient in the private sector has every incentive to give up their insurance and tell you about it, because if their insurance doesn't pay their bill, they pay it. In the VA, the belief is that if you use your insurance, you lose it. And so why tell that you have the insurance, because if you don't have insurance, we don't bill you. And so there is no incentive to share the information that you have insurance.

Secondly, for physicians in the private sector, if a physician doesn't bill and bill accurately, their hospital suspends their privileges or they don't get paid. Pretty clear, personal, up front. And timeliness is an issue. If our physicians don't do that, we could potentially discipline them, but given our pay structure, we are challenged to get people to come to work for us at a fraction of what they might make in the private sector already, and so we have no real incentives or actions we can easily take to ensure timely and accurate medical documentation.

I hope that as we review the quadrennial review on physician pay and send forward a pay reform for physicians in the VA, that that package will include variable pay for physicians so that a portion of their pay will be at risk for the quality and the quantity of work that they provide, and the quality would include documentation in the medical record.

Thirdly, we have an outstanding computer system for delivering care, and the private sector has an outstanding computer system for billing. The Leapfrog Group, which is a consortium of private sector Fortune 500 companies trying to improve quality in health care, has as its number one priority to improve the safety of health care computerized physician order entry. The private sector might have 5 percent computerized physician patient entry. We have 75 percent. We far outstrip them in terms of quality of care.

We do a lousy job at billing because our system is designed to give care, not to bill. Because prior to 1988, we did not bill and prior to 1998, the collections went to the Treasury, not to the sites that did the work. They only stayed in business if they were able to bill. And so we have a significant challenge, I think, in the way our computer systems were set up that we are trying to overcome.

And finally, we have challenges in hiring high quality medical record coders as is true in other health care systems across America today. We may need your help in allowing us to demand that coders have to be certified. It is our current understanding that we can't require certification in coding as a condition for employment in the VA. We also have relatively little flexibility to pay them what we need to pay them in the competitive environment.

So I make no excuses. We have lots of work to do. I think that we have made significant progress. We have considerable progress to make, and I would look forward to working with this committee to design a system that gives better results. Thank you.

[The prepared statement of Dr. Garthwaite, with attachment, appears on p. 81.]

Mr. BUYER. You know the reality, Doctor, is that we have changed the face of VA. So you can say that when you look back over your career, you can say, well, the culture of the VA is only to focus on the providing of care, true, when it was service-connected disabled veterans. There were many in the veterans community when you will look back who were frightened of the thought that as we reduced the number of patient inload, that will there be a VA in the future? Will we go to some outpatient, outsourcing of VA health care?

And then there was this almost panic that the way to save the brick and mortar of the VA is to reform its eligibility. And now we have all of those Category 7s. As we go to Category 7s, if we don't use best business practices, shame on us. That is why you are not doing it, because you have gotten the gravy train of our liberal generosity going to the VA.

So we have to change because the face—and VA and what we do and what we provide has changed. So we have to think like a business. Bringing business practices and principles to the government should not be a radical concept. I am not lecturing, I am just trying to speak openly here.

Let me yield to Ms. Carson.

Dr. GARTHWAITE. I would agree with that.

Ms. CARSON. Thank you very much, Mr. Chairman.

Dr. Garthwaite, thank you very much for being here. You certainly have been a standard-bearer for many congressional hearings. And I heard you say you look forward to helping design a system. I hope that means you rescinded your——

Dr. GARTHWAITE. No, ma'am, it doesn't. You can do a lot in a month if you work hard.

Ms. CARSON. We appreciate your excellent service before you leave the VA. I have one quick question then, not directly related to the MCCF.

Americans are in a time of crisis, as we know. Is the VHA prepared to cope with the fourth mission of the VA, in which the VA

will supplement the DOD domestic health care system in a time of war or crisis?

Dr. GARTHWAITE. Yes, ma'am. We are currently doing a variety of things with regards to the terrorist attacks. Since last Tuesday we have provided post-traumatic stress counselors in New York City and Washington, DC. We have provided nurses especially for critical care units.

I think one of the challenging questions, though, is: Do we have enough beds—total beds both in Department of Defense and the VA. They have downsized their military treatment facilities. We have certainly downsized our inpatient facilities. We are in the process of looking not only at the number of vacant beds that we can make available that we have already established in a short period of time, but we are beginning to look at are there any beds that we have closed that we could open up quickly.

But I think we stand ready. We have trained staff. We know where our experts are. We know how to get ahold of them. We are ready to do our mission.

Ms. CARSON. Thank you.

Mr. BUYER. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

First, Dr. Garthwaite, and Ms. Carson alluded to it, will be leaving the VA. I guess you are going to be retiring sometime soon. You are too damn young to be retiring.

Dr. GARTHWAITE. Retiring from government service, sir.

Mr. BILIRAKIS. Anyhow, sir, our thanks for all of your service over the years. Our thanks for the many times that you have not only—we are so thankful. We got a spinal cord injury in Tampa Haley Hospital in that regard, but coming to these hearings, we have gotten to know you real well. You have always been pretty darn candid. And I don't know—I hope our Chairman doesn't mind if I want to sort of lead the applause to you for all that you have given our veterans over the years.

Dr. GARTHWAITE. Thank you. And it has really been an honor.

Mr. BILIRAKIS. Thank you, sir.

Just very quickly, Dr. Garthwaite. Now, your points are well taken in terms of the different types of patients and maybe the reluctance on the part of the patients to basically divulge the fact that they have insurance and things of that nature. And your points are well taken, there is no question about that. But we don't feel—and the testimony has been here to the effect that the VA is not being diligent enough. You know, our budget was set out on the basis of what the certain amount of money would be available from third-party collections. It has turned out to be a heck of a lot less. There has been raiding. I know the two VISNs that involve Florida—I hate to get parochial, because it is not a parochial question, but the two VISNs that involve Florida, the money has been diverted from those VISNs to other VISNs around the country, and those were the two best producers in terms of third-party collections in the country among all of the VISNs. Coincidence? I think not. But that is not what we should be doing.

And I would just like to—I am not going to ask any questions, because Mr. Udall should have his opportunity, but I would just implore the VA, let's take advantage of this. Let's do it in the right

way. Let's not be more aggressive in collecting the payments from the—the copayments on the part of the veteran than we are trying to collect it from the insurance companies.

Thank you very much, Doctor.

Dr. GARTHWAITE. Thanks.

Mr. BUYER. Thank you. Mr. Udall.

Mr. UDALL. Thank you also for your service, Doctor, and I wanted to ask Ms. Sagar, because she is managing this facility here at Martinsburg, and apparently you are achieving better results than your other peers at VA locations. What is your opinion of the solution to this MCCF problem as you have been listening to what we have identified here today?

Ms. SAGAR. I can't hope to speak to what would work at other VA facilities. What I can tell you is what works at Martinsburg, and we have a lot of best practices. I think, as someone mentioned previously, that you have to treat this as a business and run it as a business.

Mr. UDALL. As the Chairman said, better business practices. Thank you very much.

Mr. BUYER. Let me follow up with Mr. Udall's question. I was a claims judge advocate in the Army, so I did third-party medical recoveries, and I had Federal civilian employees work for me, and I set goals for them and gave bonuses and fought for their bonuses. I found out how hard it was to get a bonus to a Federal civilian employee. Does the VA system have a system set up for you as a manager to be able to give bonuses, and are you using them as incentives for collection goals?

Ms. SAGAR. Yes. There is an incentive awards program, and we do utilize that. Last year when we met our collection goal, we had a huge party. The medical center funded the food, and the medical center director approved the staff being given time off later. So that was one of the incentives for fiscal year.

Mr. BUYER. Parties are great, but they don't buy Nikes or Reeboks for kids for school——

Ms. SAGAR. True. There is also an incentive program that involves cash, cash awards.

Mr. BUYER. You utilize cash bonuses to those employees?

Ms. SAGAR. Cash bonuses and time off awards.

Mr. BUYER. Very good. No wonder you are popular.

Mr. UDALL. Mr. Chairman, can I follow up a little further here.

Mr. BUYER. Yes.

Mr. UDALL. I have got a hypothetical situation here, Ms. Sagar. I am going to tell you about a veteran, and tell me what you all would do. A service-disabled veteran desires to have health care at Martinsburg for a nonservice-connected complaint. This veteran has third-party medical insurance coverage through their spouse, but the third-party plan has a substantial unfilled deductible and a copay of about 25 percent of treatment cost. The veteran hopes to avoid the deductible and the copays and believes that by not revealing that fact that they have third-party medical insurance, they will pay less overall. Is this true, and what are the considerations here, and how would you handle that?

Ms. SAGAR. Yes, it is true, and it happens quite often. A lot of time what we will do is review the database, see what is in there

as far as the employer for the veteran and the spouse, and look for any signs or hints that he may have health insurance coverage.

Mr. UDALL. So you get to the root of the problem right at the beginning?

Ms. SAGAR. We follow up and try to aggressively pursue the fact that he may have insurance coverage.

Mr. BILIRAKIS. If Mr. Udall would yield.

Mr. UDALL. I will yield.

Mr. BILIRAKIS. But isn't that false information regarding on a Federal form on the part of that veteran? That is pretty serious stuff.

Ms. SAGAR. I am sure it is.

Mr. NORRIS. We are looking at changing the enrollment form that would be more explicit in that regard so that when the veteran does sign his enrollment, he would be certifying either he does or does not have health insurance. So you are right.

Mr. UDALL. So you don't think the form at this point is good enough to deal with this kind of issue, that it could be improved upon more.

Mr. NORRIS. Yes, sir. We think we can improve it.

Mr. BUYER. All right. Let us pow-wow for just a moment as we close.

Ms. CARSON. Can you tell me how long that form has been there? And I want to tell you, I know your name is Sagar, but I think you are wonderful, and that is why I called you "Sugar." I wanted that corrected.

Ms. SAGAR. Thank you.

Ms. CARSON. Do you know how long the enrollment form has been out there?

Ms. SAGAR. Are you referring to the 1010 registration form?

Mr. NORRIS. The 1010 EZ has been out 3 or 4 years.

Mr. BUYER. A pow-wow here is this point. I want to thank my colleagues and Ms. Carson for being here. I spent 3 years in medical cost recovery. I have a passion about efficiencies in government. The work that I have done with Mr. Woys to get rid of deficiencies in TRICARE and the military health delivery system, our quest to save 500 million because of how we bill, I am going to bring the same thing to this issue and this subcommittee. We are not going to waste the time of the IG and the GAO for them to be redundant in their recommendations of 1997 and 1998. How much did you spend on this report to go out and have redundant recommendations from the IG and GAO?

Mr. NORRIS. It was largely done by our staff, and I don't know how much time——

Mr. BUYER. We are going to have a series of questions we would like for you to answer, and we are going to have a continuous dialogue with the VA, because this is one that we are not going to let go of.

Thank you for your testimony. The hearing now is concluded.

[Whereupon, at 12:13 p.m., the subcommittee was adjourned.]

APPENDIX

U. S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

Oversight Hearing on VA's Management of the Medical Care Collection Fund

CHAIRMAN STEVE BUYER

OPENING STATEMENT

The hearing will come to order.

Good morning!

The tragedy we all experienced on September 11 at the World Trade Center of New York City, at the Pentagon less than three miles from here, in the Pennsylvania countryside, and here in the Capital and across the nation has brought us all together as Americans.

Our thoughts and prayers go out to the families and friends who have been directly affected by this cowardly attack on America. We should take pause, count our many blessings and reflect on our renewed national resolve. It is important how we as a nation respond to this level of barbarism. President Bush said it best, "Terrorists can break our buildings, but they cannot break our strength." I believe God will heal this nation, but He will do this with us individually.

It is time to get back to work. We cannot allow this tragedy to consume our daily lives. And that is why we are having this hearing today. The President just signed a $40 billion counter-terrorism bill. It now becomes much more critical that VA long, abysmal history of weak oversight and management of its collections process become history.

This is the subcommittee's second hearing on the Medical Care Collection Fund. In September 1999, the subcommittee heard from various witnesses about the management problems at the VA related to the MCCF. The former VHA Chief Financial Officer stated at that time that the department had put several initiatives in place to address its poor performance.

In April 2001, almost two years later, the full Committee also questioned the VA's continued inability to effectively collect. At the hearing, Secretary Principi stated, "I also believe that we need to do a better job in medical care cost recovery. You've given us the right to retain those dollars in the VA medical care system and every dollar we leave on the table, that we don't collect because of poor management or whatever the case might be, is a dollar that doesn't go to VA health care, and to me that's unacceptable. You know, we've been at this now for over 10 years. I just believe that we haven't quite got it right. It's something that was never part of our core mission, never part of the culture, the institution of the VA, and we simply have not been aggressive enough in collecting the dollars."

Today we will hear the views of representatives from the General Accounting Office, the VA Inspector General, private sector leaders in the field of third party payer collections, and representatives from the Department of Veterans Affairs.
Through their testimony, we should be able to get an idea of what progress the VA has made in fixing the problems that were identified two years ago, and what still can be done to further improve the performance of the MCCF.

At this point, I would like to thank the veteran's service organizations that submitted a statement for the record. Your participation in the process of bettering the care that our veterans receive is, as always, both welcome, and appreciated.

Today, we are going to revisit many of the issues that were brought up at the first hearing, which the VA said it would address. In the two years since that hearing, a number of Inspector General reports have been issued that detail the apparent lack of progress that the VA has made. I suspect that this will be further evidenced by the findings of the General Accounting Office.

The VA annually estimates how much it will take in through the MCCF, and it factors that into its yearly budgetary requests to Congress. Annually, the VA has grossly overestimated its revenues. This then leads to

the VA coming back to Congress to complain that it hasn't received enough funding.

I'm glad to see that because of the VA's adoption of the "Reasonable Charge" system, the collection revenues have gone up, and this year they look like they will meet their projections. This is truly a positive turn of events. Because of this I am hopeful that the VA will not have to come to Congress asking for supplemental funding.

However, I am still disturbed that it appears that the VA has not eliminated many of the problems that have plagued the MCCF over the years. The way that documentation of medical treatment is carried out and the way that the treatment is coded for billing purposes has serious problems.

Additionally, the tremendous backlog of claims, and their estimated values, filed with insurance companies can at times be mind numbing. The time that it takes for most Medical Centers to prepare a bill and submit it to the insurance company is unacceptable.

The recent Combined Assessment Program Review that the IG issued on the VA Tennessee Valley Healthcare System illustrates my point. How am I, as Chairman of the VA Oversight and Investigations Subcommittee, supposed to tell my good friend and colleague, Congressman Zach Wamp of Tennessee, that the veterans in his district have been deprived of $10.5

million over the past two year because of an enormous backlog of 70,205 claims?

Quite frankly, I don't know the answer. However, I do want to know, and I want to stress that I am hoping to get some answers regarding exactly what the VA intends to do about this unacceptable circumstance.

The millions of dollars that the VA, and by extension the veterans themselves, don't see, could be used for a multitude of things to improve the level of care and treatment.

As gloomy as all this sounds, some MCCF directors at various medical centers have truly done a good job in managing their funds, and their work should be recognized. Also, there are private sector companies that specialize in third party collections. I look forward to hearing their suggestions regarding ways to improve this system.

After this hearing, I hope that the VA will undertake a serious review of the way the MCCF is administered. I expect them to make changes to the aspects of the system that don't work, and seek ways to integrate the successful techniques that we hear about today into the standard operating procedure of the program.

We have a full schedule, and a Full Committee hearing immediately following this meeting, so I'll now recognize our Ranking Democrat, Ms. Carson.

Statement of Honorable Lane Evans
Subcommittee on Oversight and Investigations Hearing
September 20, 2001

Thank you Chairman Buyer and Ranking Member Carson for holding this hearing today.

Fifteen years ago, Congress authorized the VA to seek reimbursement from third-party health insurers for the cost of medical care furnished to insured veterans for nonservice-connected medical care.

About ten years later, Public Law 105-33, authorized the VA to retain collections from third-party insurers at the local level -- this included medical centers and VISNs. From August 1997 onward, medical centers and VISNs were empowered to help themselves in collecting revenues to improve their programs for veterans.

Unfortunately, some medical centers and VISNs have not fully utilized this revenue improvement tool. They fail to see the benefit of a robust coding and collections team. They ask for additional funds for programs, yet some improperly manage the third-party collections fund. They DO NOT collect their fair share. This is not an area for a medical center or VISN to skimp on talent.

If the medical cost recovery team were aggressive and successful, the additional revenue would permit recruitment of talented medical care providers and enhance or expand services. This subcommittee must find and disseminate the success stories and must not accept mediocre performance from MCCF managers.

Mr. Chairman, I look forward to hearing from our witnesses this morning.

Statement of Honorable Julia Carson
Subcommittee on Oversight and Investigations
Hearing to review VA's Medical Care Collection Fund
September 20, 2001

Thank you Chairman Buyer.

I would like to take this time to welcome all participating panel members.

Today the issue is recovering the cost of medical care from third party insurers. Every successful private and public hospital in America is able to accomplish this task to a satisfactory level. They recover costs – or they go out of business. Here the VA's track record in medical cost recovery is not nearly as strong as its counterparts in the private sector. Private sector facilities usually rely on their funds collections activities as their principal means of revenue – they generally can't tap into Congressionally appropriated funds and therefore must do a better job at recouping medical costs.

This is an issue that has had significant oversight over the past few years. Today, we have experts from the GAO, the VA IG and the private sector all testifying on this issue. In the past, we have had numerous groups – some expensive consultants – look into centralized vs. decentralized processing and in house vs. contracting-out options. Despite this intense oversight, the MCCF did not show a significant improvement until this fiscal year. Some of this improvement may be due to the effectiveness of VA's reasonable cost billing system – but the VA still falls short of the private sector. Why?

Funds recovered using the MCCF supplement appropriations and may be used at the local level to improve healthcare. With effective patient registration, medical documentation, treatment coding, billing and a robust follow-up on outstanding accounts Medical Centers and VISNs augment their appropriated funds. Good management seems to indicate that the VA should maximize the effectiveness of the MCCF. This, on the surface, would seem to make sense.

On panel #4 we have called a witness, Ms Karen Sagar of the Martinsburg VA Medical Center in West Virginia, a leader who is effectively managing her MCCF. Mr. Chairman, we need to find out what is working and get everyone on that bandwagon. In Mrs. Sagar's written statement, she states that she has people in her collections unit, Accounts Receivable Assistants she calls them – she says that they are "very persistent and assertive" and that they will exhaust all means to obtain a valid payment. Each of these people has specific expertise on how to deal with specific insurance carriers. This may not be the only piece in the puzzle to finding "best practices", but I think it shows the right attitude – I can't wait to hear her testimony.

Let us look forward to finding a solution; dwelling on past failures lends little to the argument.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Thursday, September 20, 2001

VA HEALTH CARE

VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections

Statement of Stephen P. Backhus
Director, Health Care—Veterans' and Military Health Care Issues

GAO-01-1157T

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) continuing efforts to increase its collections from veterans' private health insurers. VA has the authority to bill and retain all collections from these third-party insurers for any health care it provides to veterans for non-service-connected conditions. Collections from third-party insurers are VA's largest source of revenue and are used to supplement its medical care appropriations.

Over the past several years, concerns have been raised about VA's ability to optimize its third-party revenues. For example, in 1997 we reported that VA was billing for medical care that it could not expect to collect.[1] In 1998, a national VA review found process inefficiencies, significant errors resulting in rework, and ineffective use of available automation.[2] In the same year, VA's Office of the Inspector General indicated that VA was not billing all appropriate episodes of care and not aggressively pursuing unpaid bills.[3] And in 1999, we testified on our concerns about declining VA collections and its uneven management improvements across facilities.[4] While these and other assessments recognize a number of largely uncontrollable factors that limit VA's potential revenue—such as the declining number of veterans and smaller bills associated with VA's shift from inpatient to outpatient care—they all found that VA's process for collecting payments from third-party payers has limited the amount of revenue it has generated.

In 1999, VA submitted a business plan to the Congress that called for an evaluation of two major alternatives for improving revenue operations and collections. Both alternatives called for each network to consolidate portions of the revenue operations, but one alternative called for using in-

[1] *VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult* (GAO/HEHS-98-4, Oct. 17, 1997).

[2] *VA MCCR National Study: Cost Assessment and Best Practices*, Coopers and Lybrand (Apr. 21, 1998).

[3] *Audit of the Medical Care Cost Recovery Program*, VA Office of Inspector General (July 10, 1998).

[4] *VA Health Care: Collections Fall Short of Expectations* (GAO/T-HEHS-99-196, Sept. 23, 1999).

house staff while the other would have used contractor staff.[6] My testimony today will focus on the status of VA's collections this past year and VA's progress in pursuing its business plan. To assess VA's efforts, we visited revenue operations at four facilities[5] and one network;[7] surveyed all facilities and networks and interviewed headquarters officials; obtained and analyzed private sector benchmarks;[8] and reviewed relevant VA studies and plans, including its September 2001 Revenue Cycle Improvement Plan.

In summary, this fiscal year, for the first time since fiscal year 1995, VA has reversed the general decline in its third-party collections. However, the fiscal year 2001 increase appears to be largely the result of VA's implementation of a new system, known as the reasonable charges billing system, which allowed VA to move from a flat-rate billing system to one that itemizes charges for the care it provides to veterans. However, long-standing problems in VA's revenue operations appear to persist, and when compared to private sector standards, VA's collections performance is poor. For example, VA takes 14 times longer to bill, on average, than a benchmark for private sector hospitals. Moreover, VA's various attempts to try consolidation using either in-house or contractor staff have provided little basis for selecting the best alternative to address VA's collections problems. For example, VA initiated a pilot to test the relative cost-effectiveness of contracting out or using in-house staff, but as a result of changes in the pilot's design for contracting, this test is unlikely to yield data needed to compare the two alternatives and determine which option is best. In addition, VA's recent 2001 Revenue Cycle Improvement Plan does not call for a comprehensive comparison of alternatives nor does it focus on net revenues—collections minus operations costs. To collect the

[6]VA could competitively determine whether it would be more cost-effective to retain the work in-house or contract it out through the use of Office of Management and Budget's Circular A-76 process. In the A-76 process, the government identifies the work to be performed—described in the performance work statement—and prepares an in-house cost estimate, based on its most efficient organization, to compare with the winning offer from the private sector.

[5]For this report, facilities will only refer to VA medical centers that have revenue operations.

[7]The management of VA's hospitals and other health care facilities is decentralized to 22 regional networks, known as Veterans Integrated Service Networks.

[8]Based on a national quarterly survey of private sector hospitals, the *Hospital Accounts Receivable Analysis* report provides averages for various billing and collections activities that can serve as benchmarks of performance.

most funds for veterans' medical care at the lowest cost, VA needs to develop a business plan and detailed implementation approach that will provide useful data for choosing the best alternative for optimizing net revenues from third-party payments.

Background

When veterans receive care from VA for non-service-connected conditions, the law allows VA to bill the veterans' private health insurers and retain these third-party collections to supplement its appropriations for health care. Third-party insurers include individual and group insurance plans, Medicare supplemental insurance plans,[9] and self-insured employer plans.

In January 1997, VA proposed a 5-year plan to operate with a flat annual appropriation of $17 billion per year through fiscal year 2002. As part of this plan, VA anticipated that by the end of fiscal year 2002, it would obtain 10 percent of its funding from third-party collections and other alternative revenue streams, such as veteran copayments, Medicare payments, and proceeds from sharing agreements (where VA sells services to the Department of Defense, private hospitals, and other providers). In fiscal year 2000, VA acknowledged that it would not meet its 10-percent goal, in part because the Congress did not authorize Medicare payments to VA for health care provided to Medicare enrollees. For fiscal year 2002, VA estimates that revenue from alternative sources would be about 4 percent of its medical care funding, or $896 million.

VA's third-party revenue operations consists of five sequential processes. (See table 1.)

[9]Medicare supplemental insurance is private insurance to cover expenses not covered by Medicare, such as deductibles, copayments, coinsurance, and prescription drugs.

Table 1: VA's Revenue Operations Processes

Revenue operations process	Description
Patient intake	Includes registration of patient information, verification of insurance, and other medical administrative services.
Medical documentation	Involves properly documenting the health care provided to patients by physicians and other health care providers, and determining whether or not the care is for a service-connected condition.
Coding	Involves assigning correct codes for diagnoses and medical procedures based on the documentation.
Billing	Involves creating and sending bills to insurance carriers based on insurance and coding information.
Accounts receivable	Includes payment processing and follow-up with insurers on outstanding or denied bills.

With the exception of six networks that have consolidated some of these processes, revenue operations management is currently decentralized and the processes are performed at each medical center where health care is provided to veterans.

In the 1990s, VA sponsored two studies comparing the cost-effectiveness of contracting out most revenue operations. The results of these studies were not fully conclusive and were contradictory. The first study, conducted by Birch and Davis and reported on in 1995, concluded that VA's costs would be slightly less if operations were maintained in-house instead of using a contractor.[10] In contrast, the second study, conducted by Coopers and Lybrand and reported in 1998, found that, based on three contractors' estimates, contracting out would be less expensive.[11]

Collections Have Increased in the Past Year, but Underlying Problems Continue

If VA's current pattern of third-party collections continues into the last months of fiscal year 2001, VA will significantly increase its third-party collections for the first time since fiscal year 1995. However, the increased collections are likely the result of VA's generally charging more for each episode of care—which occurred with the implementation of billing reasonable charges for individual services. Not only do long-standing

[10] *Medical Care Cost Recovery Cost of Collections Study*, Birch and Davis Associates, Inc (Oct. 17, 1995).

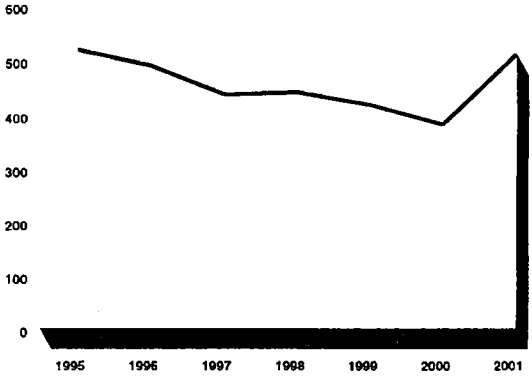
[11] *VA MCCF National Study: Cost Assessment and Best Practices*, Coopers and Lybrand.

problems in revenue operations appear to persist—which have been heightened with the implementation of reasonable charges—when compared to private sector benchmarks, VA's collections performance is poor. Moreover, the revenue program's information systems and lack of departmentwide standardization create overarching weaknesses for managing and improving revenue operations and collections nationally.

VA Collections Have Increased Since the Implementation of Reasonable Charges

Based on monthly collections for the first 10 months of fiscal year 2001, we project that VA will receive over $500 million from third-party collections this year. This amount is a significant increase over last fiscal year—and the largest amount collected since fiscal year 1995, when $523 million was collected. (See fig. 1.)

Figure 1: Third-Party Collections Since Fiscal Year 1995



Note: 2001 projection calculated by GAO based on VA Revenue Office data.

VA expected its collections to increase as a result of its reasonable charges billing system, which was implemented in September 1999. Under this system, VA began using itemized billing for the services provided—rather than charging flat fees, as it had done prior to 1999. According to a VA

analysis, in the first 8 months of fiscal year 2001, VA treated about the same number of patients but collected 34 percent more dollars than the comparable period in fiscal year 1999 before reasonable charges were implemented.[12]

Long-Standing Problems in VA's Revenue Operations Limit VA's Collections Performance

Although the implementation of the reasonable charges billing system has increased VA's collections over the past year, VA faces a number of long-standing problems in managing its revenue operations. In addition, VA's collections performance falls short of private sector benchmarks.

Inadequate intake procedures, lack of sufficient physician documentation, shortage of qualified coders, and insufficient automation diminish VA's collections.

- Patient intake: To determine which veterans have insurance, VA must rely on voluntary disclosure of insurance by veterans.[13] Nationally, VA bills insurers for only 16 percent of patients treated but reports that substantial numbers of veterans have probably not disclosed their insurance.
- Medical documentation: About 74 percent of surveyed facilities reported that weaknesses in physicians' documentation of care for billing purposes limits collections. One official was concerned that his facility could not meet its timeliness goal unless clinical staff provided more timely documentation for billing. He also noted that not all billable care could be charged to insurers because of incomplete or insufficient documentation. A VA contractor this year estimated that VA could collect $459 million more nationally if physicians' oversight of resident physicians was properly documented. However, the contractor also found that some physicians were concerned that spending more time on documenting care for billing purposes would take away from the time spent with patients.
- Coding: VA has acknowledged its difficulty maintaining sufficient staff who can correctly code medical procedures and services for billing. A 2000 study also found these problems and attributed them to competition from other employers for coders, low VA entry-level wages, and VA's frequent problems with retaining and promoting qualified and proficient

[12]In fiscal year 2000, as facilities adjusted to the new requirements to bill under reasonable charges, national collections initially decreased.

[13]According to a VA official, no other reliable source exists. In addition, unlike beneficiaries with private insurance, veterans are not responsible for paying the remainder of their VA bills, and thus do not have the same financial incentive to disclose insurance to VA.

staff.[14] At three sites we visited, for example, revenue officials noted that they had difficulties hiring experienced coders at VA salaries.

- Billing: A VA-sponsored 2001 study of the possible uses of commercial software found limitations in VA's current billing software that led to manual processes. As a result, there is an increased probability of errors, slower production, and lower collections. A contractor who provided services to both VA and private sector hospitals also told us that VA's process for creating bills and identifying errors is less automated than the private sector.
- Accounts receivable: The majority of VA's accounts receivables exceed 90 days and VA is concerned that insufficient follow-up is given to collections. According to a contractor that services both VA and private sector hospitals, VA staff at one facility were not following standard business practices of contacting insurers to resolve problems with bills but instead were just sending additional copies of bills. At another site we visited, two accounts-receivable staff were having difficulties reducing a backlog of about 3,000 to 4,000 unpaid claims because each day they were only able to make a total of 60 follow-up calls to insurers.

Private sector hospitals appear to manage these processes more efficiently.

- VA's average lag times from the date of discharge or care to the date of billing are 74 days for inpatient care and 143 days for outpatient care. In comparison, private sector benchmarks indicate that 5 and 6 days, respectively, are more typical in the private sector hospitals.
- The majority of VA's accounts receivables are over 90 days old from date of discharge or care, compared to a private sector benchmark of 29 percent of uncollected dollars exceeding 90 days.
- A VA-sponsored 1998 study estimated that VA's full cost to collect one dollar of third-party revenue was 7 cents for inpatient bills and 48 cents for outpatient bills, compared to a benchmark of slightly over 2 cents in the private sector.[15]

[14]Gary Nugent et al., "Third Party Billing in the VHA: A Look at Cost and Policy," *Federal Practitioner* (Nov. 2000).

[15]The large difference between VA's inpatient and outpatient costs to collect resulted, in part, because VA had to generate approximately 20 outpatient bills to produce recoveries equivalent to 1 inpatient bill.

Comparisons between VA and private sector hospitals, however, are not perfect because their operations and payer mix differ. For example, VA bills both for facility and provider charges, whereas the two private sector hospitals we visited only billed for facility charges; medical groups bill separately for physician fees. In addition, VA can only collect on the Medicare supplemental portion of the payment, whereas the private hospital can collect both Medicare and supplemental payments. VA reports that about 70 percent of its bills are sent to Medicare supplemental insurers, and for these, it can only expect to collect abut 20 percent of the billed amount. Consequently, VA would have a higher cost-to-collect ratio even if it were as efficient as its private sector counterparts. Although these differences make comparisons with private sector average performance imperfect, the disparity of performance suggests that the average VA operation is not very efficient.

Implementing Reasonable Charges Created New Process Challenges and Exacerbated Existing Ones

By replacing a billing system that used a limited number of flat fees for broadly defined types of care with one based more on individual charges for the services actually given, the new reasonable charges system made accurate coding and documentation more critical for billing and increased workload because multiple claims could result from a single episode of care.

Before implementing its reasonable charges billing system, VA used nine inpatient rates, based on a particular hospital unit, such as a surgical bed section, and one outpatient visit rate. Under the reasonable charges billing system, VA assigns hundreds of diagnoses codes and thousands of procedure codes based on the documentation of the services provided to veterans. Therefore, before reasonable charges, an outpatient surgery, such as one to repair a hernia, would result in one all-inclusive charge. Under reasonable charges, VA must now create separate bills for physician charges and for outpatient facility charges for the same outpatient surgery. Although estimates varied at the sites we visited, one official estimated that using reasonable charges increased the number of bills by about 5 times.

Officials at all sites we visited reported acquiring more staff—both in-house and through contracts—to process bills under reasonable charges. For example, since reasonable charges was implemented, one site's total number of coders and billers more than doubled, from 7 to 19. Based on the 133 facilities reporting to our survey, increases of VA staff continued into this fiscal year. Full-time equivalent positions for revenue operations

have increased from 2,284 in fiscal year 2000 to 2,411 by the middle of fiscal year 2001.

Decentralized Responsibilities Also Present Challenges

VA is also challenged to successfully direct and manage a highly decentralized program with practices and performances that vary widely by facility. VA has noted that although its national policies address key components of revenue operations, they are not followed in a standard and consistent manner. For example, VA has encouraged physicians to enter their notes electronically; however, physicians at one location we visited were dictating their notes for transcription, which were then transferred to the electronic system. At another site, an official told us that while other facilities were able to create an electronic interface with an intermediary to transmit bills to insurance companies, his facility had not. Therefore, bills were keyed in and printed, then re-keyed in by data entry staff to allow electronic transmission to the intermediary.

Collections performance also varies widely from facility to facility. For example, one facility takes an average of 16 days to send an inpatient bill, while another averages 342 days. Facilities' performance in cost to collect were similarly diverse. According to data reported to us by facilities for the first half of fiscal year 2001, VA's average personnel cost to collect a dollar was 24 cents across both inpatient and outpatient bills,[16] with facilities in the top 25 percent of performance reporting personnel costs to collect a dollar ranging from 5 to 15 cents and facilities in the bottom 25 percent of performance reporting personnel costs to collect a dollar ranging from 31 to 64 cents.

In addition, the data accumulated from the various facility systems are not adequate to nationally manage performance. VA notes that the lack of software and data standardization across facilities impairs its ability to consistently measure performance and set performance goals. Moreover, because VA's accounting system does not break out third-party collections or operations costs, net revenues (that is, gross revenue collections minus operations costs) cannot be monitored at a national level. According to an official at VA's national headquarters, data on facility performance are also unreliable because they are not verified. For example, some facilities

[16]VA's full cost to collect would be even higher if nonpersonnel and other overhead costs (such as supplies, equipment, and senior management) were added. For example, according to Birch and Davis' 1995 study of VA's costs, travel, postage, and other indirect costs accounted for about 10 percent of total costs.

reported high and unreasonable numbers—such as thousands of days to bill—which the facilities could not explain. It is not clear then, whether variations in facility performance reflect better or worse performance or unreliable data.

Efforts to Improve Collections Provide Little Basis to Select the Best Alternative for Optimizing Net Revenue

The various efforts VA has undertaken to improve its revenue operations fall short of providing a basis to select among the two major alternatives—contracting out or using VA staff. VA's 1999 business plan to the Congress indicates that contracting could improve operations by incorporating the private sector's best billing and collection practices and efficient automation. While some networks and facilities have contracted out portions of their revenue operations, these efforts do not provide VA the data needed to compare contracting with using in-house staff. Moreover, VA's efforts have not sufficiently considered the importance of net revenues—collections minus operations costs—a key criterion for choosing among alternatives. VA also initiated a pilot to test the relative cost-effectiveness of contracting and using in house staff, but as a result of changes in the pilot's design, it is unlikely to yield data that allow comparisons of each alternative's net revenues.

At the Secretary's initiative, VA developed its 2001 Revenue Cycle Improvement Plan. Our preliminary assessment of the plan is that it also will not provide VA a sufficient rationale to choose wisely among alternatives for optimizing net revenues.

Some Networks and Facilities Are Using Contracting

VA's 1999 business plan indicates that once networks consolidated their revenue operations, contracting might improve operations because competitive bids for the contract should reflect the cost of an efficient operation. The business plan also indicates that contract incentives and the desire to keep the contract could encourage contractors to keep costs down and profitably collect every billed dollar. The 1999 business plan further suggested consolidating some network operations with a high-performing VA unit within the network as a comparison to contracting. Both approaches could increase standardization of processes and introduce best practices.

Some networks have consolidated some revenue operations. Networks and facilities have also used contracting, but these contracting efforts have primarily been small-scale and aimed at addressing immediate problems. Few facilities have contracted out an entire process of revenue operations. (See table 2.)

Table 2: Consolidation and Contracting of Revenue Operations Processes

Process of revenue operations	Network consolidation (22 networks)	Network contracts (22 networks)		Facility contracts (133 reporting facilities)[a]	
		All of process	Some of process	All of process	Some of process
Patient intake[b]	27% (6)	0%	5% (1)	0%	17% (23)
Medical documentation[c]	NA	NA	NA	NA	NA
Coding	0%	14% (3)[d]	27% (6)	4% (5)[e]	35% (47)
Billing	14% (3)	0%	32% (7)	1% (1)[f]	42% (56)
Accounts receivable	18% (4)	0%	41% (9)	0%	69% (92)

[a]Six facilities, including five in one network with consolidated operations, did not report to us.

[b]Counted as "all of process" if contractors did all of the intake tasks of pre-registration, insurance identification, and insurance verification.

[c]Medical documentation must be done by VA clinical staff at facilities.

[d]Counted as "all of process" if contractor coded either all inpatient or all outpatient cases.

[e]Counted as "all of process" if contractor billed either all inpatient or all outpatient cases.

VA facilities and networks reported to us that most of their contracts are viewed as temporary to meet immediate needs, such as supplementing their staffs to reduce backlogs of claims. Revenue operations managers also voiced a number of concerns that indicated that they would be unlikely to pursue extensive contracting. Our survey showed that less than 1 percent of either network or facility revenue-operations managers reported that contracting out the majority of revenue operations would be the most effective alternative. In addition, they noted various implementation barriers that would have to be resolved. For example, contractors would need to be trained about VA's rules and regulations, an interface between VA's and the contractor's computer systems would need to be developed, and union issues that would arise around the loss of VA jobs would need to be addressed.

A recent VA-sponsored survey of eight health care revenue collection firms and a VA-hosted vendor conference indicated that contractors have an interest in performing most revenue processes—from intake through accounts receivable—and they had anticipated some of the barriers facilities and networks identified. For example, contractors identified the need to establish an interface with VA's data systems. Without such an interface, the contractor might only be able to provide contract workers to use VA's data systems rather than to bring the full capacity of the

contractor's own data systems to improve operations. The contractors also believed that if the contractor were only engaged in the latter parts of revenue operations—billing and accounts receivable—the effect on increasing collections would be limited because generating additional revenue is critically affected by front-end activities such as insurance identification, documentation, and coding.

While there were similar concerns about consolidation, it appears to have more acceptance among VA revenue managers than extensive contracting. In our survey, 36 percent of network respondents and 11 percent of facility respondents indicated that network-level consolidation would be the most effective alternative for managing third-party collections. For consolidation, respondents cited union and morale issues regarding the movement or loss of jobs and sharing information between facilities as implementation challenges.

Pilot to Test Contracting Out Will Not Provide Needed Data

VA has initiated a pilot that was intended to test the contracting alternative and to use the data from this test to evaluate whether consolidation using in-house staff or contractors would improve net revenues and other key outcomes. However, it fails to meet this key objective. While the pilot may provide some information on whether consolidation of some processes at a network-level could improve net revenues and other outcomes, it will not provide useful data for choosing between the in-house and contract options because a pilot site for gathering similar information on contracting was not established.

According to a VA headquarters official, the networks were reluctant to volunteer for the pilot because of concerns that if the contract did not work out, they would have lost the expertise of the in-house employees who had worked on revenue operations. Two networks have agreed to pilot the consolidation using in-house staff alternative, and a third network will pilot consolidation with limited contracting out. A fourth network has contracted out one task of patient intake—insurance verification.

This fourth network had also planned to use another contract for coding, billing, and accounts receivable, although retaining VA employees to process backlogs in these same areas. This pilot could have yielded useful data for comparing the two alternatives. However, after a number of delays and plans to limit the contract to 3 months at a single facility, VA has not found an acceptable contractor and even this abbreviated test of contracting out is unlikely to occur.

Current Improvement Plan Focuses on Enhancing In-House Operations, Not Net Revenues

VA's Revenue Cycle Improvement Plan, finalized in September 2001, does not position the Department to choose between the two major alternatives for optimizing its third-party collections because the plan does not call for a comprehensive comparison of these two options nor does it focus on net revenues—collections minus operations costs. Instead, the plan seems to present a decision to improve in-house operations in the short term, and later consider the alternatives.

In the short term, the plan calls for 24 actions to address problems throughout VA's revenue operations—such as training coders and tracking documentation—over a 2-year period. However, the plan does not establish a way to gather data on the alternatives because nearly all of the efforts to improve revenue processes are to be undertaken at the facility level with VA staff. The only planned consolidation would be establishing, for a 3-month period this year, a single in-house group at headquarters or using a contractor to handle accounts receivable older than 90 days.

VA also plans to implement in the near term three national contracts for electronic services. However, these contracts will primarily supplement facilities' billing and collection efforts rather than replace VA operations. One nationwide contract will establish an electronic data interchange for the electronic submission of bills to insurers to help ensure faster turnaround of payments and reduce errors due to automated edits during the transmission process. A second contract—a Medicare Remittance Advice contract—will provide an explanation of what Medicare would have paid for VA's medical services, thereby clarifying the remaining amount for the supplemental insurer to pay. The third contract—a lockbox contract—will replace the current manual, paper-based process of receiving and posting payments with an automated process.

The plan's vision for considering both consolidating and contracting is for the longer term. For example, the plan calls for considering the viability of contracting out billing and accounts receivable as well as the supporting software system after the 24 actions have been taken.

Moreover, although the September 2001 plan calls for cost-benefit analyses for specific proposed actions with major investments, the plan is unclear as to how VA will decide which, if any, investments it will make prior to deciding whether it will choose the contracting alternative. For example, the plan indicates the need to acquire a new computerized billing and collections system—which according to a 2001 VA-sponsored study of commercial software could be a major investment, likely from $75 million to $125 million. However, in a discussion of future contracting, the plan

states that VA could avoid large capital expenditures and gain a faster deployment if it used a contractor that provided the billing and accounts receivable software.

Finally, the plan does not consider net revenue. Without such a consideration, VA will not be able to measure the extent to which funds are actually generated to supplement appropriated funds for veterans' health care.

Concluding Observations

VA's efforts to date have not provided it the data needed to compare program expenditures and collections and to choose among the major alternatives of contracting or using in-house staff for its revenue operations. Nor does VA establish net revenue as a criterion in its recent improvement plan to address weaknesses in facility managed operations and later consider the in-house staffing and contractor alternatives. Without a credible business case for increasing expenditures that result in more net revenue, VA's budget officials will be at odds regarding how to spend sizeable portions of VA's resources—on revenue operations or on medical care.

While VA has used competitive sourcing to a limited extent, it could realize additional savings by competing, through the use of OMB's Circular A-76, the costs of government providing these services in-house versus the costs of buying them from the private-sector. Our work at the Department of Defense shows that, by competitive sourcing under OMB Circular A- 76, costs decline through increased efficiencies whether the government or the private sector wins the competition to provide services.[17] This work indicates that savings are probable for VA, but we cannot estimate potential savings from competitive sourcing because of uncertainty regarding the availability of interested contractors, the price of contractor services, and the extent to which VA is able to decrease its operating costs in a competitive process.[18]

[17]See *DOD Competitive Sourcing: Some Progress but Continuing Challenges Remain in Meeting Program Goals* (GAO/ NSIAD-00-106, Aug. 8, 2000) for a discussion of the benefits of competing various efficiency options using the OMB Circular A-76 process.

[18]See *DOD Competitive Sourcing: Savings Are Occurring, but Actions Are Needed to Improve Accuracy of Savings Estimates* (GAO/ NSIAD- 00-107, Aug. 8, 2000) for a discussion of calculating savings under the OMB Circular A-76 process.

A recent House Committee on Appropriations' report accompanying the fiscal year 2002 appropriations bill includes funding for VA to create a demonstration of a contractor-installed and operated financial system for revenue operations. Such a demonstration might provide an opportunity to test the contracting alternative relative to in-house alternatives. The contractor's financial system, which would supplement VA's system, would be a prototype under the demonstration. It is intended to provide functions to overcome current deficiencies in such areas as verifying insurance, accumulating all charges for care, ensuring proper coding, producing bills, and managing the collections process.

VA's current pilot has consolidated operations at some networks, and its recent improvement plan is designed to improve in-house operations over about a 2-year period. If VA then gathered appropriate information on net revenues and other key outcomes for these alternatives, it would be better positioned to make a fact-based decision among them in a manner envisioned by OMB A-76.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

Contact and Acknowledgments

For further information, please contact Stephen P. Backhus at (202) 512-7101. Ron Guthrie, Terry Hanford, Jean Harker, Mike Gorin, and Karen Sloan also made key contributions to this testimony.

(290016)

STATEMENT OF THE
HONORABLE RICHARD J. GRIFFIN

INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CARE COLLECTION FUND

September 20, 2001

Mr. Chairman and Members of the Subcommittee, I am here today to report on our work concerning the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF). During the past several years, the Office of Inspector General (OIG) has reviewed selected VA MCCF issues and has identified opportunities to enhance MCCF recoveries.

Background

In accordance with Title 38, U.S.C. 1710, 1712, 1722A, and 1729, VA collects reimbursements from third-party health insurers and certain veterans to offset the cost of medical care and medications for treatment of nonservice-connected conditions.

The Balanced Budget Act of 1997 (Public Law 105-33) authorized VA to establish the MCCF, which replaced the Medical Care Cost Recovery (MCCR) program. VA now retains all MCCF collections to be utilized to provide additional health care resources for our nation's veterans.

Public Law 105-33 also authorized VA to bill "reasonable charges" for medical care provided on or after September 1, 1999. Reasonable charges are defined as amounts that insurers would pay private sector health care providers in the same geographic area for the same services. Billing reasonable charges is more labor intensive and time consuming than billing cost based per diems, but it results in higher recoveries.

The effectiveness of billing reasonable charges relies upon accurate documentation of the medical care provided, use of consistent business processes, and compliance with policies and procedures. Billing and collection is

the end of a process that includes determination of eligibility and entitlement when a patient checks in, verification of the patient's insurance coverage, coordination of care with an insurance carrier, complete and accurate documentation of treatment in the patient's medical record, and accurate coding of the diagnosis and/or medical procedures provided using industry standard codes, such as the International Classification of Disease (ICD-9) and Current Procedural Terminology (CPT-4) systems. All these processes must work together to produce timely and accurate bills, and ultimately collections.

VHA expected that the authority to bill for reasonable charges and the ability to retain MCCF revenues would motivate managers to increase collection efforts. VHA established minimum annual MCCF collection goals for its Veterans Integrated Service Networks (VISNs) and member medical facilities to further encourage MCCF efforts. As shown below, between Fiscal Years (FYs) 1998 and 2000 collections were essentially flat, and VHA did not achieve its collection goals, even after lowering the FY 2000 collection goal 10 percent below the FY 1999 goal. However, collections have increased significantly through the first 10 months of FY 2001 and are on pace to exceed $750 million for the year. According to MCCF program managers, the increased collection rate is due in large part to implementation of the higher billing rates under reasonable charges.

Fiscal Year	Goal (Millions)	Collections (Millions)
1997	$544	$520
1998	$634	$560
1999	$671	$574
2000	$605	$573
2001	$605	$632 (through 07/31/01)

Previous Audit Effort

On July 10, 1998, we issued "Audit of the Medical Care Cost Recovery Program, Report No. 8R1-G01-118." (www.va.gov/oig/53/reports/98-2reports.htm) We determined that VHA could increase MCCR recoveries by over $83 million by requiring VHA facilities to (1) use management tools, such as preregistration software, to identify and bill insurance carriers more timely, (2) more aggressively pursue collection of accounts receivable, (3) establish and monitor performance standards for MCCR staff, and (4) demonstrate how MCCR recoveries benefited veterans.

VHA concurred with our findings, recommendations and estimated benefits. The VHA action plan included VISN-based training sessions and tasking for procedural changes to implement OIG recommendations. VISN Directors were also required to establish appropriate performance standards. VHA held meetings with Veterans' Services Officers and distributed informational brochures describing third-party billing and the circumstances under which veterans would

make co-payments. Additionally, veterans were informed that MCCR collections would be returned to benefit veterans in the region where the revenues were derived.

Combined Assessment Program Reviews

Our Combined Assessment Program (CAP) reviews provide an independent and objective assessment of key operations and programs at VA medical facilities on a cyclical basis. CAP reviews completed at VA medical facilities since March 31, 1999 have identified the following MCCF program weaknesses:

- Facility staffs were not effectively determining veterans' eligibility and entitlement status.
- Facility staffs were not effectively verifying and coordinating patient care with insurance carriers.
- Medical record documentation of care provided was not adequate.
- Bills to insurance carriers were not accurately coded.
- Bills to insurance carriers were not issued in a timely manner.
- Collection efforts on delinquent accounts were not aggressively pursued with insurance carriers.

For example, a recent CAP review disclosed 70,205 backlogged third-party reimbursement claims valued at about $10.5 million. In addition, the time required to prepare a bill following delivery of outpatient care averaged about 241 days. Studies have shown that shorter billing lag time improves recovery rates. The Facility Director estimated that the VAMC could increase MCCF recoveries by about $3.2 million by processing outpatient bills that are currently backlogged.

In response to each of the MCCF weaknesses identified, facility management agreed to take the necessary corrective actions that we recommended.

Current Healthcare Inspection Effort

The OIG, Office of Healthcare Inspections (OHI) is evaluating the effectiveness of VHA's efforts to improve the accuracy of coding medical services provided to veterans.

We reviewed outpatient coding accuracy, data reliability, training initiatives, and implementation of compliance programs at 15 VA medical facilities visited during Fiscal Year (FY) 2001. Our review showed that employees need to focus their attention on reducing the coding error rate for outpatient visits, and improving

their internal control processes. About 50 percent of the 570 outpatient visits reviewed contained coding errors, which was significantly higher than the 30-percent error rate Health Care Finance Administration (HCFA) reported from its review of private sector billings in 1996.

During FY 2000, VHA recovered about $155 million from third-party billings pertaining to outpatient services.

We found that medical record documentation did not consistently support the codes assigned, which resulted in the VA overcharging or undercharging for services rendered. For the billable visits reviewed, the error rate was 43 percent. Of these visits, 67 percent were up-coded, while 33 percent were down-coded. Third-party payers had reimbursed some of these bills at the incorrect rate, and managers told us that they would contact the insurance companies involved and make the necessary adjustments. The 43 percent error rate is unacceptable and represents a significant risk. We found a number of billable visits in which bills had been cancelled because of inadequate documentation or lack of attending physician documentation. While canceling these bills was appropriate to avoid inaccurate billing, revenue was lost due to poor documentation.

We concluded that VHA managers need to set incremental goals to improve outpatient coding accuracy, data accuracy, and training for clinicians and coders.

Current Audit Effort

We are currently conducting an audit of FYs 2000 and 2001 MCCF billings and collections. We are assessing MCCF policies, procedures, and operations to (1) determine the accuracy and timeliness of MCCF third-party billing for inpatient care, (2) evaluate the effectiveness of MCCF accounts receivable management, and (3) follow-up on the implementation of recommendations made in our 1998 audit report.

Although collections are increasing in FY 2001, interim audit results show potential for significant additional collections. Conditions identified in our 1998 report, including missed billing opportunities, billing backlogs, accounts receivable management, and procedures to identify and verify patient insurance coverage, still need improvement. The following are some of the problems we have identified to date.

Billing Backlogs

Timeliness of billing affects the amount collected. We reviewed the days elapsed from the date of care to the date of billing for billings randomly sampled from 3,918,136 bills issued during the period October 1,1999 to September 30, 2000. On average, 95 days elapsed (84 days average for inpatient bills and 108 days average for outpatient bills). By contrast, our 1998 audit found a 48-day average

to bill for services and, in calendar year 2000, private industry averaged only 10 days to issue bills.

VHA's Unbilled Care Report, cumulative as of July 2001, showed that $931 million had not been billed ($254 million for inpatient care, $660 million for outpatient care, and $17 million for prescriptions). We estimate that based on VHA's current collection rate (approximately 34 percent of the amount billed), issuing the bills comprising this backlog could result in additional collections of approximately $317 million.

Missed Billing Opportunities

Our review of randomly sampled cases from 739,634 FY 2000 patient discharges identified a number of cases that should have been billed. These missed billing opportunities occurred primarily because the treatment provided by attending physicians was not adequately documented in the medical record to establish the bill of collection. Based on the sample results, we estimate that VHA missed the opportunity to recover $18 million for inpatient care provided to 47,000 veterans during FY 2000.

Accounts Receivable Management

We also reviewed third-party inpatient treatment bills randomly sampled from a universe of 234,464 FY 2000 bills valued at approximately $1.37 billion. We found that VHA staff did not follow-up with insurance carriers on delinquent receivables as required by VA policy in 77 percent of the cases reviewed. Collections increase when staff follow-up on delinquent receivables. We estimate that VHA lost the opportunity to collect $117 million by not following-up with insurance carriers.

Insurance Identification

Questionnaire responses received by us from 135 VHA facilities indicated that 24 facilities (18 percent) were not using preregistration software as required by VHA. The software helps identify insurance coverage and collect information before the veteran comes to the facility for treatment. We recommended that VHA use this software to improve identification of patients with health insurance in our 1998 audit report. VHA program officials told us that veterans are more willing to provide health insurance information through this process.

Implementation of 1998 Audit Recommendations

We also found that other recommendations made in our 1998 report were not effectively implemented. VHA had not established performance standards for clinical and administrative staff conducting patient registration, coding, billing, collection, and utilization review. Further, VHA still needs to better educate

veterans about the importance of MCCF collections to the medical facility and to dispel any misconceptions veterans might have regarding loss of insurance coverage or increased premiums upon disclosing insurance information to VA.

Based on our current audit to date, we believe the Under Secretary for Health would further improve MCCF activities by:

1. Directing that VISN and VA medical facility Directors ensure that billing opportunities are not missed, the backlog of bills is eliminated, and future bills are issued timely.

2. Communicating MCCF performance goals/expectations to VISN Directors and medical center directors and holding them accountable for results by measuring their performance and addressing performance gaps.

3. Establishing performance standards for clinical and administrative staff involved in all phases of the MCCF (patient registration, coding, billing, collection, and utilization review) and requiring VISN and VA medical facility Directors to monitor performance results and take action to improve performance.

4. Expanding training for personnel involved in the billing process (patient registration staff, physicians, coders, billers, collection staff, and utilization review staff).

5. Ensuring that VA medical facilities use the preregistration software as required.

6. Following up with insurance carriers on delinquent receivables, as required by current policy.

7. Continuing to promote the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

By effectively implementing our previous recommendations, we believe VHA could have increased collections by $135 million in FY 2000. By clearing the backlog of $931 million in Unbilled Care, VHA could increase current collections by an additional $317 million.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the subcommittee may have.

Testimony by Mr. James E. Woys, President and Chief Operating Officer, Health Net Federal Services

Mr. Chairman and Members of the Subcommittee - I am pleased to be here today to address the committee on commercial practices employed in the health care industry with regard to coordination of benefits practices between insurance companies when a patient is insured by more than one company.

I am Jim Woys, President and Chief Operating Officer of Health Net Federal Services, a division of Health Net, Inc. (HNI). HNI is one of the top 5 managed care companies in the nation, with over 10,000 employees servicing 5.7 million covered lives in a full line of medical, dental and behavioral health insurance and HMO products. The Government and Specialty Services Division includes my company, Health Net Federal Services (HNFS), and currently holds three TRICARE contracts as well as 11 VA contracts across the country. We are responsible for the administration and servicing of over 2 million beneficiaries who depend on the federal government for their health care benefits. More than 2,900 dedicated employees of my company and our subcontractor companies bring their collective commercial expertise to the government under these contracts.

My purpose today is to share the approaches used by my company within TRICARE administration and our industry in the private sector when coordinating health benefits payment responsibility among multiple health plan payers.

There are significant dollars involved in the management of health plan benefits for all plan sponsors, including government-sponsored programs. Based upon a nationally respected actuarial consulting firm's findings, savings in health care costs associated with Coordination of Benefits (COB) among carriers can range from 3 percent to over 6 percent of total paid claims. Additionally, since 85 percent of our nation has health insurance under at least one health plan, and many people are covered by more than one plan, the opportunity for avoiding overpayment of claims through coordination of benefits is immense. The chart below indicates the makeup of our nation's health insurance coverage for 1998 and 1999. Because many people are covered by more than one insurance plan the sum of the following is more than 100%.

Type of insurance	1999	1998
Non Government plans	71 %	70 %
Government plans	24 %	24%
Medicare	13 %	13 %
Medicaid	10 %	10 %
Military Health Care *	3 %	3 %
No insurance	15 %	16%

*Military Health care includes CHAMPUS/TRICARE CHAMPVA, Veterans and Military Health Care.

The opportunity for financial recovery is too great to ignore for health insurance companies and the sponsors of health programs who must be fiscally responsible for limited resources and the high demands placed on our health care system.

Effective health program administrators include a disciplined approach to ensuring overpayments are avoided when an individual has more than one form of coverage, and when overpayments occur, they are quickly and effectively recovered. I will outline the principles used in our approach to coordinating with other companies to avoid overpayments, but before I do, I would like to define a couple of terms that will help us start with a common understanding of some key references.

Other Health Insurance (OHI) is the term used when a plan beneficiary has other health care coverage available through an employer, an association, a private insurer, a student's health care plan obtained through his or her school, or any other entitlement program. Also referred to as "double coverage", other health insurance is typically the primary payer in government sponsored health plans. As an example, federal law requires that TRICARE benefits are always secondary with the exception of Medicaid and certain policies specifically designated as TRICARE supplements.

An Explanation of Benefits (EOB) is a document provided by insurance companies to the service provider and beneficiary detailing what services were covered, which were excluded from coverage and what was paid for each covered service. This form also lists any deductibles and co payments that were taken into account when determining payments. This form has sufficient detail to allow other insurance companies to calculate their COB payments

accessible to anyone using the system, and for claims processors to refer to when processing a claim.

- Each provider is required to ask the covered person if they have other insurance coverage and to indicate this on the claim form before submitting it for payment. In those instances where the "other insurer" information on the claim is different from what is currently in our system, a COB questionnaire is mailed to the covered person to verify the information received from the provider. If the information the covered person provides agrees with the information shown by the provider, the COB screen is updated to reflect the new information.
- In order to ensure that our COB records are current, a COB questionnaire is sent out annually to those individuals who have not submitted one within the last 12 months.
- Other than scenarios mentioned above, any contact with a provider, the covered person or claims recovery company, which indicates that our COB records might not be current, is followed up to obtain the most current data available.

In summary, the key to timely and accurate identification of other health insurance is gathering information at every opportunity and collecting it in a centralized data base environment that everyone can utilize as a single source for enforcing the collections effort in claims administration.

ENFORCEMENT

Once other insurance information has been collected and validated, action must be taken to enforce each insurer's coordination of benefits or Third Party Liability (TPL) rules.

The claims processor staff must compare the covered person's information and dates of service on the claim to the information in our COB records to determine if the person had other insurance coverage when they were treated.

If there is other coverage the processor must determine which insurance policy is primary to the others. There are industry-wide rules that offer two principle approaches that insurers or plan sponsors use to determine the order of payment responsibility among multiple payers. The predominant COB rule is the "birthday rule" which states that the policy covering the person with the earliest birthday is primary. In the event that the COB provisions of two plans cannot be reconciled The McGurl Case (US court of appeals for the Third Circuit – March 1997) held that the National Association for

Insurance Commissioner (NAIC) rules would be federal common law and would take precedence over the other provisions. The NAIC rule is the birthday rule.

If it is determined that another carrier is primary, the claims processor looks for an Explanation of Benefits (EOB) from the other insurer showing what benefits were paid under its policy. The secondary coverage would then pay its share to the claimant, whether it is the provider of care or the covered person who submitted the claim.

In the event that an EOB is not supplied, the claim is suspended and a copy of the EOB is requested before the secondary benefit coverage can be determined and the claim can be processed.

RECOVERY OF PAYMENT

In the best of systems, some claims will be overpaid and will need to be recovered. We recover claims using both our internal staff and outside claims recovery contractors. In instances where the overpayment is easily identified and providers continue to file claims, overpayments are recovered by offsetting the overpayment against a current claim for the same provider.

When we contract outside claims recovery firms to work as a COB clearinghouse, they identify unreported COB issues and pursue more difficult recovery cases. We provide the clearinghouse vendor with selected fields from our claims records that are compliant with HIPAA regulations. The clearinghouse vendor then matches what we provide against claims records of many other insurers seeking potential matches that would indicate that a claimant has multiple insurance policies. This information is then validated by the claims processing staff and any overpayments due to the coordination of benefits are identified and recovered.

TRICARE PROGRAM

My company manages three regional TRICARE contracts for the Department of Defense. Our COB activities, called Other Health Insurance (OHI) or double coverage by statute, are similar in many ways to commercial practices, but are also different in some very important areas.

IDENTIFICATION

In support of the TRICARE program, my company uses the following tools to identify OHI coverage:

- Enrollment applications - Beneficiaries enrolling in the TRICARE HMO option, called TRICARE Prime, must complete an enrollment application, which, among other questions, asks for OHI information much like the commercial plans do. This information is entered into an OHI screen in our claims system which is accessed during claims adjudication.
- Provider supplied information on submitted claims - OHI information for sponsors or beneficiaries who choose to utilize the TRICARE fee for service option, called TRICARE Standard, is captured from claims submitted by providers.
- OHI questionnaires - Periodic questionnaires are sent to providers and beneficiaries as needed.
- Service contacts with sponsors and beneficiaries – Any time a TRICARE beneficiary seeks services from the program, there is opportunity to update or obtain any new OHI information from the beneficiary.

To increase the effectiveness we also utilize several additional tools to find unreported OHI coverage.

- Claims Audits: Paid claims audits are performed to identify and recover overpayments due to double coverage and we use the results of these audits to update the OHI screens in our claims systems.
- Newsletters/Publications: There are quarterly newsletters and publications we prepare and distribute to beneficiaries and providers that include educational articles on their responsibility to report OHI coverage.

ENFORCEMENT

The largest difference between the TRICARE program and commercial COB rules is that TRICARE is statutorily determined to be secondary coverage with a few notable exceptions such as Medicaid, TRICARE supplemental plans, Indian Health, and other programs identified by the Director of the TRICARE Management Activity (TMA).

As with commercial plans the overriding principle of TRICARE double coverage rule is to ensure that beneficiaries receive maximum benefits from their health coverage, but no more than they are entitled to receive, and that the combined payments do not exceed the total charge for the service or supply.

The OHI screens in our claims systems are integrally linked with the enrollment system to ensure up-to-date OHI coverage information is used when processing claims. When OHI does exist, an EOB is required from the other payer(s) before the TRICARE claim can be adjudicated. If an EOB has not been provided, the claim is suspended and a questionnaire is sent to the beneficiary or provider who submitted the claim. This questionnaire must be completed and returned to us in a timely manner or the claim will be denied.

The key to effective OHI or double coverage management is the accuracy and currency of our OHI data. The data collection starts upon receipt of an enrollment application from a PRIME beneficiary then continues thorough claims adjudication and during each customer contact. Our OHI screens are updated whenever we obtain OHI information different than what we currently have.

RECOVERY

Due to a variety of reasons, TRICARE, as with commercial plans, can overpay claims which then need to be recovered. Recovery efforts are generally concentrated on providers because the majority of claims are paid directly to them. Recovery methods used, which are similar to commercial plans, include:

- Credit balance recovery - Credit balances can result from misposting accounts in a hospital's books, erroneous payments by insurance companies or two or more insurance companies paying as primary rather than one as primary and one as secondary.
- Paid claims retrospective review - Paid claims files are provided to a claims recovery contractor who has access to the claims files for over 1,500 health insurers in the country. The contractor compares claims files to those of the other insurers to determine if the covered person is insured by more than one company. If such a match is found we work with the provider to recover any overpayments.
- Overpayment recovery - Claims overpayments are recovered by working with the overpaid provider to obtain voluntary reimbursement, offsetting amount to be recovered against current

claims payment to the provider, or utilization of a collection agency if the first two approaches are unsuccessful.

Recovery tools that are unique to TRICARE include:

- Investigation by Program Integrity:
  Cases are at times referred to our Program Integrity unit for review for potential fraud. Whenever such a referral is received, the OHI information reported by the provider and beneficiary is validated. If new information is obtained our OHI records are updated.
- DRG validation review:
  The DRG validation review is a contractual requirement to review paid claims data for overpayment to DRG facilities. The purpose of the process is to ensure that the facilities billed correctly and were paid appropriately and part of the review includes an assessment for overpayment as a result of OHI or TPL.

The result of these efforts amount to millions of dollars in recovered health care costs. It amounts to as much as two percent in the TRICARE environment. Approximately 40 percent of recoveries are from paid claims and approximately 60 percent are from overpayment recovery and program integrity review.

In many cases both commercial insurance plans and TRICARE plans pay claims submitted for their beneficiaries even though the responsibility for the ultimate payment rests elsewhere. These payments are made to ensure that our customers receive medical care at the time it is needed for injuries resulting from auto accidents, work related injuries or accidents. These payments, identified as third party liability claims are the responsibility of companies providing Auto Insurance, Worker's Compensation or Liability policies and efforts to recover TPL payments are instigated after our patient has been treated.

State and Federal laws and regulations, as well as the terms in the various insurance policies determine the collectability of these claims. Commercial insurers and the TRICARE program devote significant efforts to understanding the rules and regulations guiding TPL recoveries, identifying those claims which are truly TPL claims, and recovering the TPL payments made from the responsible insurance company.

SUMMARY

In summary there are several issues that need to be addressed by a health plan sponsoring company or government agency if they wish to maximize their COB savings and TPL recoveries.

1) **Knowledge of COB/TPL Rules:** Determine who owns the COB and TPL recoveries. Program administrators should understand the COB and TPL rules in their policies and be able to interpret the rules of other plans to determine the order of payment responsibility.
2) **Knowledge of COB/TPL Regulations:** Rules vary within federal government programs and from state to state when determining when you can apply your COB rules. Some federal and state regulations allow insurers to "chase & pay", obtaining COB information before paying the claim, while others require insurers to "pay & chase", paying the claim then seeking COB recovery.
3) **Institute business processes that are adequate to identify potential COB and TFL savings:** Obtain and record other insurer information on a regular basis using all available contacts with beneficiaries and providers and store the information in a centrally placed database that can be used when adjudicating claims.
4) **Ensure centralized database integration among claims payments systems and other administrative applications:** Automatic matching of claims being adjudicated to your COB files is faster, more accurate and effective.
5) **Decide on in-house administration or external contracts:** If you do not have the ability to build an effective and cost efficient COB/TPL operation internally, there are many reputable companies who can perform this role to meet your specific needs and circumstances.
6) **Link other health plan operations to the COB/TPL effort:** There are other sources of OHI and TPL information in the operations of today's comprehensive managed care programs. In particular, medical departments or utilization and medical management personnel receive current information concerning OHI existence or possible TPL recoveries that can be valuable in pursuing other coverage.
7) **Educate:** There must be an extensive and consistent effort to educate health plan providers (hospitals, physicians, ancillary services) as well as the beneficiaries themselves. Often, the providers' information collection at time of services being rendered is the timeliest information available. It is important to facilitate the capturing of the information easily by program staff and educate providers on the importance supplying accurate OHI/TPL data.

CLOSING REMARKS

In this testimony, I have addressed many elements that contribute to a successful program for third party or other health insurance collections. In review of these points, ***information collection*** is the fundamental element for building and maintaining effective recovery programs.

There has to be a disciplined approach to collecting information wherever administrative interactions occur with a covered beneficiary or their provider of care. It is essential that the health program's administrative processes and data storage systems support this effort in a systematic way.

If these underlying practices are in place, then the VA can expect to realize the maximum potential benefit of a third party collections effort and ensure the health care resources of VA health programs will serve our veterans' best interests.

Thank you for the opportunity to present my comments to you today. I look forward to your questions and comments.

STATEMENT OF
EDWARD GASKELL
PRESIDENT
OF
ADVANCEMED CORPORATION, A DYNCORP COMPANY
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS

Mr. Chairman and Members of the Subcommittee:

We thank you for inviting AdvanceMed Corporation to express its views on specific approaches the VA may want to consider in its financial management of third-party collections. I am accompanied today by Maria Caschetta, AdvanceMed's Senior Vice President. Our organization provides a wide range of coding services to hospitals and health systems nationwide, including Veterans Administration Medical Centers (VAMCs) and another contractor working for the Revenue Office at VA Headquarters. We are known for success in the Federal government with regard to starting up and managing high-risk, centralized programs, which call for large-scale production operations. These programs involve abstracting and coding clinical data, validating clinical diagnoses and procedures that are coded and billed by providers, medically reviewing coded services submitted on claims and their supporting medical record documentation, handling large quantities of medical records in secured facilities, and developing the infrastructure for working with medical facilities, peer review organizations, and payer organizations, including the electronic tracking systems that ensure accountability for medical record location and status of workload handled by AdvanceMed. These centralized programs consolidate highly skilled and specialized healthcare information and technology resources. They service the common needs of multiple, remote user organizations. They generate measures of the work performed through implementation of standardized internal quality assurance programs developed by AdvanceMed. One of these contracts calls for AdvanceMed to function as an independent review entity responsible for generating data that the government can use to evaluate system, contractor, and program performance. The following paragraphs provide more detail concerning AdvanceMed's insight into problems that the VA faces with respect to the coding industry, their unique requirements that the private sector does not face, and possible solutions for accomplishing the coding work needed to generate bills for third party reimbursement.

AdvanceMed Corporation is a wholly owned subsidiary of DynCorp, one of the largest employee-owned service companies in the nation, headquartered in Reston, VA. DynCorp is a leader in providing outsourcing and information technology solutions to Federal, State, and local government agencies. AdvanceMed employs over 1,100 healthcare information management and services delivery professionals; its clients span the private and public sectors -- principally hospitals, healthcare systems, managed care

plans, state agencies, other businesses, Department of Veterans Affairs (DVA), Department of Defense (DOD), Department of Health and Human Services (DHHS) Office of Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS) (formerly known as HCFA), and the Consumer Product Safety Commission (CPSC).

Most noteworthy for this testimony is AdvanceMed's experiences as direct services organization for over 50 hospitals and healthcare delivery systems, including Veterans Administration Medical Centers, and contractor for CMS' Clinical Data Abstraction Centers (CDACs) and Program Safeguard Contractor (PSC) task orders, principally the Comprehensive Error Rate Testing (CERT) Program.

For hospitals and health systems, AdvanceMed provides a wide range of coding and related auditing services on an outsourcing or staff-augmentation basis. Facilities are located in many states throughout the country; some require on-site support and others send work to AdvanceMed as part of a remote-coding solution. AdvanceMed provides individuals experienced in coding systems used by institutions for billing inpatient, outpatient surgery, outpatient clinic, and emergency department services. For VAMCs and VA special study efforts, AdvanceMed also provides professional fee coding of institutional episodes of care.

AdvanceMed's CDAC operations provide centralized services, principally to CMS and its 52 Medicare Peer Review Organizations. Primarily, these services include clinical data abstraction, admission necessity screening, DRG/coding validation, and support in developing and testing data collection tools and new coding systems, such as the ICD-10 procedure classification system. AdvanceMed develops and implements aggressive and comprehensive internal quality control programs and participates in external quality assurance activities led by CMS. It also develops and maintains electronic administrative workload reporting and tracking systems, and tests different approaches with respect to the storage and handling of medical records and data abstracted from them.

As CMS' CERT, AdvanceMed receives extracts of all claims processed by Medicare Contractors on a daily basis, draws samples for error rate testing, reviews the claims and their associated medical records to determine whether a payment error has been made and the underlying reasons for error. Expected outcomes include determination of national and sub national error rates for use in performance monitoring and improvement. In addition, this contract provides the government resources for special studies associated with Medicare payment and policy matters and provider billing and care delivery practices.

The models developed and implemented for the CDAC and CERT call for comprehensive, systematic, and standardized approaches that will support high-volume production operations utilizing highly skilled, high-demand resources. One serves to support remote users with specialized services, the other serves to provide the government with independent, objective processes and findings in support of external quality assurance and performance measurement requirements. Lessons-learned from

starting up and maintaining these programs gives insights into solutions that may help the VA face the challenge of getting records coded for subsequent billing and revenue collections.

A major problem facing the VA as it moves toward improving revenue collections is the shortage qualified, expert coders. The shortage is compounded by the following situations:

(1) Coders tend to develop expertise in certain types of coding (e.g., ICD-9-CM versus CPT) but not necessarily all types of coding required for third-party reimbursement.
(2) Many coders tend to work exclusively on certain types of records (e.g., inpatient versus outpatient clinic);
(3) Coders tend to specialize in the types of coding required of the specific providers who employ them (e.g., hospital, other institutions, professional fee);
(4) In the private sector, physicians and other independent practitioners depend on coding for obtaining revenues for services they deliver; therefore, coders they employ tend to specialize in the domains represented by their clinical specialty (e.g., radiology versus anesthesiology, versus multi-specialty);
(5) The complexities and vagaries in medical documentation coupled with the diversity of coverage and reimbursement requirements by fiscal intermediaries, carriers, and government agencies makes it extremely challenging to qualify and educate individuals to provide quality coding functions; and
(6) Low salaries offered by hospitals and government systems coupled with environmental issues result in an unstable coding workforce.

The situations listed above result in having to hire a number of personnel to cover the spectrum of coding requirements which the VA must perform in a market where qualified and experienced personnel may not be drawn to work directly for hospitals or health systems. Further, the VA has unique features and requirements that do not permit wholesale adoption of existing private sector strategies to accomplishing coding tasks, such as

(1) Designation of conditions and treatments that are connected to military service disabilities and the exemption of treatment for service-connected conditions from third-party reimbursement;
(2) VA physicians and other independent practitioners are salaried and because they do not receive professional fee reimbursement for each patient, are often not aware of the importance of proper coding or incentivized to perform the required documentation;
(3) VA resident trainees enjoy the benefits of learning from unpaid or shared faculty from affiliates; however, this means that such attending physicians are not compensated by the VA for their services for specific patients;

(4) VA is responsible for coding that drives both institutional and professional fee reimbursement; and
(5) Certain VA facilities get professional support from other VA hospitals (e.g., through telemedicine approaches).

AdvanceMed believes that the Veterans Health Administration (VHA) may benefit from centralized approaches to handling (1) specialized coding functions required of V A Medical Centers in their efforts to bill for services eligible for third-party reimbursement, and (2) evaluation of services provided by centers that may be set up for this purpose. The following should be considered when establishing such resources:

(1) Implement national or regional (e.g., at the Veterans Integrated Services Network (VISN) level or groupings of VISNs) contracts with companies expert in providing coding services and handling large-scale production operations in support of decentralized stakeholders.
(2) Implement comprehensive record and administrative workload reporting & tracking systems to ensure proper accountability for medical records and workload at all times.
(3) Implement specific standards and/or requirements for significant workload processes, production, timeliness of turnaround, quality, training programs, currency of work products, staff certifications and suitable waivers based on experience and demonstration of performance (e.g., through test results, etc).
(4) Require ISO registration to be achieved by contractors within one year after implementation. This will give confidence to the VA that contractors managing and staffing large-scale coding operations have the required standards, systems, policies and procedures documented and in place for running and sustaining a successful, high-risk business operation.
(5) Require implementing a comprehensive quality assurance program, which reports on metrics, corrective actions, etc.
(6) Retain control within the VAMC health information management area for evaluation of the quality of coding provided by the centralized or regional contractors. Small samples could be drawn continuously or on a schedule, qualified hospital personnel could verify the coding done in the sample, where there are disagreements, discuss them with the coding contractor, come to consensus, determine error rate and related findings for corrective action.
(7) If VAMC Health Information Management (HIM) personnel are not available to do the quality evaluation of records coded for their facility, then allow them to contract to a centralized resource for independent quality evaluation, or accept findings of the coding contractor's Internal Quality Control program coupled with feedback from billing personnel on claims rejections due to coding problems.
(8) Prioritize use of centralized coding resources -- first for work subject to third-party collections then for all other coding work as needed by VAMCs to keep workload current.
(9) Establish a system where initially records are printed (for electronic sources) and copied (for hardcopy sources), packaged using a standardized approach,

and sent by mail to the contractor for coding. Consider implementing on-line access to records at VAMCs where they are completely electronic, provided that (1) the system works efficiently, i.e., no or little down time, no or little response delay, easy to access all components required for coding, (2) security within the system can withstand latest HIPAA requirements as interpreted and adopted by the VA, and (3) entry of codes and use of required encoders can be accomplished efficiently.

(10) Require the coding contractor to document and report back on items that cannot be coded due to documentation problems or can be coded but should not be billed due to specific deficits.

CLOSING

AdvanceMed appreciates the Subcommittee's invitation for us to testify today. Our objective has been to offer possible solutions for the VA to consider in their financial management of third-party collections, in particular with respect to requirements it has for coding clinical conditions and treatments. AdvanceMed values the work it is doing for VHA with regard to professional fee coding, providing staff augmentation services to help reduce backlogs and maintain current workload, and providing specialized coding resources and health information management consultation to another VA contractor in support of a special study involving revenue collections. We believe that the VA would benefit from (1) adopting a centralized or regionalized model that provides a systemic, standardized, and consistent resource of highly specialized technical coding services, and (2) retains VAMC control over assessing the quality of that resource as part of a systematic process that produces valid and reproducible performance metrics.

STATEMENT OF
THOMAS L. GARTHWAITE, M.D.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

SEPTEMBER 20, 2001

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Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the progress, challenges, and future direction of the Department of Veterans Affairs (VA) Veterans Health Administration's (VHA) revenue program. Accompanying me are Mr. Jimmy Norris, VHA's Chief Financial Officer, and Mr. Don Pratt, Acting Associate Chief Financial Officer for Revenue.

To provide some good news at the outset of my testimony, collection statistics through August 2001 of this fiscal year show a collections total of over $708 million, which is an increase of nearly 40 percent over last fiscal year collections for the same time frame. We estimate that total fiscal year collections will be over $750 million, which will be the largest amount of collections experienced in the history of the revenue program. Even with this large gain in collections, there is potential for increased collections.

At the Secretary's request, VHA prepared a detailed report on how to improve collections. A copy of that report has been provided to the committee and a brief description of the plan is attached to my statement. We are making a concerted effort to develop clear management responsibility for all aspects of the program and are striving to hold all employees accountable. We are stressing improvement in data capture, insurance identification and records documentation to enhance the billing process. We are also

stressing the need to build a strategy for resolving weaknesses in the current billing and collection process. The strategy may include outsourcing some or all billing and collection functions. This topic is discussed later in this testimony.

Background

In 1986, Public Law 99-272 gave VA authority to seek reimbursement from third-party health insurers for the cost of medical care furnished to insured nonservice connected (NSC) veterans. This law also authorized VA to assess a means test copayment to certain NSC veterans. The copayment is based on the veteran's income and assets.

Public Law 101-508, enacted in 1990, expanded VA's recovery program by providing authority to seek reimbursement from third party payers for the cost of medical care provided to insured service-connected veterans treated for NSC conditions. The law also authorized the per diem copayment and medication copayment programs.

Additional laws were enacted which extended the sunset provisions for billing health insurance carriers of service-connected veterans for their NSC conditions and copayment billing authority. Legislation is currently pending to further extend these authorities.

Public Law 105-33, enacted August 5, 1997, established our current Medical Care Collections Fund (MCCF) and authorized VA to retain collections from health insurers and veterans copayments at the local medical center/VISN level. Prior to this law, these collections, less administrative costs, were returned to the Department of Treasury.

Public Law 105-33 also granted VA the authority to begin billing reasonable charges. Reasonable charges are based on amounts that third parties pay for the same services furnished by private sector health care providers in the same geographic area rather than cost-based per diems. VA had used average cost-based per diem rates for billing insurers. Reasonable charges are calculated for inpatient facility charges, outpatient facility charges, and professional or clinician charges for inpatient and outpatient care.

Since inception, VA collections have increased from $24 million in FY 1987 to an estimated $750 million in FY 2001. We have made improvements in our operating

processes and systems through the years. We have taken what was a very labor intensive manual process and automated much of the billing and collections. We have provided automated processes such as pre-registration, claims tracking, autobiller, and several data capture initiatives, as well as enhancements to the integrated billing and accounts receivable packages in the Veterans Health Information Systems and Technology Architecture (VistA) to assist in billing and collections activities. The changes to the VistA system have replaced the majority of the manual processes once utilized. However, additional changes are still necessary to fully automate our billing and collection process.

Insurance Identification

Historically, approximately 15 percent of the total enrolled veteran population has reported billable health insurance. Through July of FY 2001, our efforts have increased that number to over 20 percent. We are actively pursuing a search for a private sector vendor to provide assistance with insurance identification. Further, we are preparing revisions to our health benefit application forms designed to encourage full disclosure by veterans of their insurance coverage.

Approximately 70 percent of the health insurance policies reported are Medicare supplement policies. Reimbursements from these policies are extremely low, and law prohibits VA from billing Medicare and Medicaid directly. HMO's and some PPO's reimburse VA only for emergency services and not for the provision of routine health care services.

Billing and Collection

Billing reasonable charges is time consuming and the accuracy of documenting the medical care provided on the bill is critical. The effectiveness of billing reasonable charges relies upon consistent application of sound business practices and compliance with policies and procedures. Billing and collections is the final component of a process that includes patient registration, insurance identification and verification, documentation of care provided, inpatient and outpatient coding of care received, utilization review, and

billing and accounts receivable. All of these components must work together for timely and accurate bills to be produced.

The July 10, 1998 "Audit of the Medical Care Cost Recovery Program" conducted by the Office of Inspector General (OIG) determined that Veterans Integrated Service Network (VISN) Directors could enhance MCCR recoveries by requiring facilities to (1) use management tools to identify and bill insurance carriers more timely, (2) more aggressively pursue collection of accounts receivable, (3) establish and monitor performance standards for MCCR staff, and (4) demonstrate how MCCR recoveries benefited the veteran.

A close review of collections from FY 1998 to FY 2000 showed that reported collections increased only slightly from FY 1998 to FY 1999. In FY 2000, 12 of the 22 VISNs did not meet their goals, and 10 of the 22 VISNs collected less in FY 2000 than in FY 1999. As a result, collections in FY 2000 were slightly lower than in FY 1999. This was due in large part to the implementation of Reasonable Charges. Billing for reasonable charges increased workload and required significant training at the medical facilities. Billing and collection activities at some facilities, therefore, decreased during this implementation phase. However, with full training of staff, collections for FY 2001 have increased significantly.

Standardization

VHA's strategic change to reasonable charges using standardized forms (UB92 and HCFA 1500) supports the larger initiative of improving compliance with all requirements and standards (both VA and non-VA). Compliance will also require improvement to VHA's patient accounting system. VHA's Office of Information (OI) continues to modify our information system to meet current requirements. Concurrently, OI is addressing the impact of future requirements and standards, such as those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), on its processes and information systems. The law mandates that standard electronic transactions be used to accomplish electronic exchange of health care information. In particular, HIPAA sets standards for certain health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. HIPAA also sets standards to address security

and privacy of electronic health information systems. Providers and health plans are required to use the standards for electronic transmissions within 24 months after they are adopted as law.

As one critical step to improve collections, the VistA system must be transformed into an "account-based" system. This means that in addition to a permanent, global patient identifier such as a medical record number or social security number (SSN), a patient account number for billing purposes should be assigned for each episode of care that a patient receives. Generally, an episode of care is defined as any of the following: an inpatient stay, a visit to the emergency room, a one-time visit to an outpatient clinic, or a set of recurring visits to an outpatient service area for such treatment as physical therapy or dialysis. One patient may have multiple patient account numbers or indirect global data elements such as SSN, medical record number, guarantor number, and enterprise record number. These features are foreign to the way that VistA operates today. While it appears that the equivalent of an account number may exist among the VistA Patient Care Encounter (PCE), Patient Treatment File (PTF), and Claims Tracking applications, the extent to which VistA may need to be modified to effectively support account-based functionality has not yet been fully determined.

The complexities brought about by VA's change in billing and collection have greatly impacted the information systems that support the revenue cycle operations, necessitating a modernized patient accounting system. VistA, VHA's information system, is an integrated set of approximately 130 modules with primary focus on clinical applications. All of VistA is developed and maintained by VHA. In this dynamic environment, VHA must consider whether continuing to develop and maintain a patient accounting system supports its core mission. VistA applications used to support the revenue cycle process have fundamental weaknesses that prohibit seamless, automated claims generation. The information technology weaknesses that most contribute to problems with claims generation and improved performance have been defined as critical weaknesses. These weaknesses adversely affect functionality and performance, and we believe that we must replace our current billings and collections software with a fully functional Commercial-off-the-Shelf (COTS) patient accounting system.

Outsourcing Healthcare Revenue Collection

I do understand that there is a great deal of interest in the issue of whether we outsource certain aspects of our Revenue Cycle. The improvement plan that has been prepared does not preclude us from considering outsourcing certain aspects of the five core processes immediately, if that is found feasible and optimal. The improvements we need to make to VistA, though critical to future considerations of the direction we may take, certainly will not keep us from considering any outsourcing until the improvements are made. I do want to stress, however, that any decision we make will be based on sound economic analysis.

As you know, we have attempted to outsource and/or consolidate parts of the Revenue process through the Health Care Revenue Collection Pilot projects. These projects were controlled tests to evaluate the implementation and outcomes of redesigned revenue collection models in four VISNs. Although we have not had much success, we have learned a great deal. In particular, it is clear that IT issues are critical. We have been unable to implement some projects due to problems surrounding interfaces, programming, firewalls, and security. Ultimately, these issues will be addressed. However, they currently limit our ability to conduct meaningful short-term outsourcing options. As with all other major decisions we make concerning revenue, future outsourcing decisions will be made with the ultimate goal of maximizing revenue collections.

National consolidation and outsourcing represent possible solutions to enhance the performance of the VHA revenue cycle. Such solutions are predicated on effective, high performing "front-end" revenue cycle processes. We are responsible for and need to improve those processes, which include patient intake, insurance identification and verification, case management, documentation, and coding functions. Our long-term strategy includes determining the viability of outsourcing all aspects of billing and accounts receivable as well as the patient financial/accounting system. The recommended actions prescribed within our Revenue Cycle Improvement Plan would enable us to move in this direction.

Revenue Cycle Improvement Plan

Our Revenue Cycle Improvement Plan identified 24 actions (see Attachment) to improve the core business processes of the revenue cycle. These action items fall within five process areas: Patient Intake, Documentation, Coding, Billing, and Accounts Receivable (AR). Many of the actions will require solutions to long-standing problematic areas of the Revenue program.

Of the 24 proposed actions, the following five are critical to the overall success of the plan:

- Implement **electronic insurance identification and verification** – an online system that verifies existing insurance policy coverage and establishes insurance coverage data when none is provided.
- Create **education programs** for veterans, clinical, and administrative staff – stress importance of accurate and complete data and monetary benefits from collection of insurance information.
- Mandate the **use of encoder and claims analyzer software** – to create a "clean and accurate" bill and to meet latest coding standards.
- **Consolidate/outsource 3rd Party Accounts Receivable (AR) follow-up** – to eliminate backlog and aggressively pursue payment from insurance carriers on aged claims to insurance carriers.
- **Standardize documentation policy** to assure that claims meet current industry standards and are complete and accurate.

Accountability, responsibility, and authority for performance and outcomes will begin at VHA Central Office and will be established for VISN and facility leadership. VHA will provide policy direction, national program support, and provide oversight for efforts at all levels. Leaders and managers at all levels will be accountable for Revenue Program results. VHA is taking immediate action in the following four core elements:

- communicating the priority of the plan's recommended actions;
- assembling integrated project teams (IPTs) composed of cross-functional VHA staff from the field and Central Office;
- having the IPTs recommend a comprehensive, detailed project plan for each specific recommended action; and

- forming a Central Office Revenue Team (CORT) to assist VISN and VAMC staff with improving revenue cycle performance

Conclusion

We project that, under our improvement plan, collections will reach $1.4 billion by FY 2005. We intend to aggressively implement the Revenue Cycle Improvement Plan to assure that we reach this level of revenue collections. This effort will be characterized by clear assignment of management responsibility and accountability for performance, improved information systems, increased level of staff competencies, and consistent application of policy across the system.

This concludes my statement, and I will be pleased to respond to questions from the Subcommittee.

Attachment

Revenue Cycle Improvement Plan

The 24 action items are:

1. Mandate pre-registration of veterans

- Besides simply reminding a patient of an upcoming appointment, the pre-registration process enables VHA to verify and/or update current demographic information and insurance.

2. Define standards for complete and accurate data capture/registration
   - Requires VHA to establish national policy defining the requirements for complete and accurate patient data capture.
3. Develop and implement veteran education program
   - Requires the development and implementation of an educational program designed to inform veterans of the benefits of collection and dispel myths about negative impact to them.
4. Develop and implement VHA employees education program
   - Requires the development and implementation of an educational program specifically for VHA employees who are required to obtain patient data on a daily basis.
5. Implement electronic insurance identification and verification
   - There are products available today that are specifically designed to assist health care organizations identify and verify patient insurance information via Electronic Data Interchange (EDI) technology.
6. Consolidate insurance information at the enterprise level
   - Establish a national resource for identifying and verifying patient insurance information as well as limit redundancies in patient intake activities nationally.
7. Develop an employer master file
   - Facilities would maintain a file of employer information and insurance information.
8. Enforce national documentation policy (M-1, Part 1, Chapter 5)

- Requires VHA to define the required data elements for patient encounters, enforce the national documentation policy.

9. Mandate use of electronic medical records (CPRS)
   - Requires VHA mandate the full and complete use of the electronic medical record such as the Computerized Patient Record System (CPRS).
10. Develop national clinical education program
    - Requires the development and use of a national clinical education program to improve timeliness of documentation to support billing.
11. Develop and mandate use of electronic encounter form & documentation template
    - Develop standardized electronic encounter forms for use in the CPRS system that can be used throughout VHA by clinicians.
12. Develop and implement documentation tracking system
    - Allow VHA to monitor timely completion of documentation.
13. Develop staffing plan for coding resources
    - Requires the development of a staffing plan for coding to address current staffing deficiencies.
14. Mandate use of encoder software
    - Provides online reference assistance and suggestions to assignment codes based on clinician documentation.
15. Develop national standard for laboratory, radiology, and other ancillary test names and corresponding CPT codes
    - Mandate system-wide use of the clinical applications to capture patient services and documentation of patient care and billing information.
16. Mandate minimum access policy to VistA ancillary packages
    - Allow billing staff minimum access to specific VistA ancillary packages.
17. Complete implementation of EDI Billing and MRA projects
    - Implementation of EDI and MRA would decrease bill lag time, improve claim accuracy, and reduce bill payment cycle.
18. Implement "claims analyzer" tools
    - Requires the implementation and system wide use of a claims analyzer tool.

19. Improve the charge capture process
    - Accurate and timely claims can only be generated when all charges are captured, are known to the billing system and relate to an episode of care.
20. Consolidate/Outsource VHA 3rd party accounts receivable follow-up
    - Requires VHA to implement and nationally mandate a consolidated approach for follow up on 3rd party accounts receivables.
21. Develop utilization review (UR) program
    - Requires development of a national education program that provides specific skill sets to help UR nurses support the revenue cycle.
22. Request VA General Counsel more aggressively pursue "referred" third party accounts receivable
    - The Revenue Office will work diligently with VA General Counsel to determine the appropriate course of action for "referred" 3rd party accounts receivable.
23. Implement 3rd party payment and remittance program (EDI Lockbox)
    - Enables the transmission of insurance payments to VHA through a contracted commercial financial institution for payment processing.
24. Implement accounts receivable management software
    - Requires VHA conduct a national implementation of accounts receivable management software and mandate its use by all facilities.

The plan includes performance measures that will be key indicators of performance and improvement.

They are:

1. Percentage of patients pre-registered
2. Percentage of completed registration
3. Percentage of insurance verified prior to discharge
4. Percentage of encounters with electronic notes
5. Bill lag time
6. Percentage of 3rd party AR greater than 90 days
7. Cost to collect
8. Total collections

STATEMENT OF
Ms. KAREN SAGAR
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MARTINSBURG VA MEDICAL CENTER
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

SEPTEMBER 20, 2001

Mr. Chairman and members of the Subcommittee, I have been invited to discuss the "best practices" of the Medical Care Collection Fund (MCCF) Program at the Veterans Affairs Medical Center (VAMC), Martinsburg, WV.

The MCCF Section at Martinsburg is organizationally aligned under the Business Programs and Operations Service. The section is comprised of 8 Full Time Employee Equivalent (FTEE) in the Coding/Billing Unit, and 14 FTEE in the Collection Unit. The section also includes two Veterans Integrated Services Network (VISN) funded units. They are a VISN 5 Preregistration Consolidation Unit (13 FTEE), and a VISN 5 Insurance Verification Unit (6 FTEE). Collections for the Martinsburg VAMC the past three Fiscal Years are as follows.

Fiscal Year 99	Total $$ Billed	$12,925,807	Total $$ Collected	$4,685,921	36%
Fiscal Year 00	Total $$ Billed	$13,352,657	Total $$ Collected	$4,695,573	35%
Fiscal Year 01 (through August)	Total $$ Billed	$12,665,664	Total $$ Collected	$5,462,251	43%

Martinsburg VAMC has been conducting preregistration calls intermittently since April 1995. In February 1999 we became the site for the VISN 5 Preregistration Consolidation Unit, conducting calls for the Veterans Affairs Maryland Health Care System (VAMHCS), the Washington, DC VAMC, as well as the Martinsburg VAMC. This Unit consists of one Lead Preregistration Clerk and twelve Preregistration Clerks.

Calls are made to patients with a scheduled appointment seven days ahead of the appointment. During this call the patient is reminded of the upcoming scheduled

appointment and at the same time their demographic information is updated. The Unit also addresses any concerns or questions the patient might have regarding the respective medical center and forwards those concerns to the appropriate personnel at the specific medical center. The procedure in the Unit is to insure that each item on the five screens of the preregistration call software is completed accurately and in its entirety on each patient that is called. These screens include employer information on the patient and spouse, if applicable, and insurance information. If the patient and/or spouse have an employer, but denies having health insurance coverage, the Insurance Verification Unit follows up by calling the employer to validate that information. Patient data is updated every six months. If a patient cannot be reached by telephone after several attempts, a form letter is sent to the patient requesting the exact information contained in the five preregistration screens. The demographic updates/changes to the VISN 5 medical center databases range from 14,000 to 15,000 each month. Each Preregistration Clerk in the Unit has access to all three medical center databases. When an insurance case is identified at one medical center, the Preregistration Clerk checks to see if the patient is seen at any of the other medical centers in the VISN and if so, enters the insurance information into the patient's file at that medical center. The same is true for any demographic changes/updates that are identified. On the average, the VISN 5 Preregistration Consolidation Unit is identifying 300 to 350 new billable insurance cases per month for the medical centers in VISN 5.

The VISN 5 Insurance Verification Unit was implemented at Martinsburg in July 2000, and consists of six Insurance Verification Clerks. The Unit is primarily responsible for verifying the coverage and benefits of each new billable insurance case identified through the preregistration calls for each medical center within VISN 5. All six Insurance Verification Clerks have access and are trained to work in the database at each medical center within VISN 5. Insurance cases identified through preregistration are verified, removed from the buffer file, and loaded in the patient's permanent insurance file at each medical center within 48 hours of identification. The Unit also verifies and loads the new insurance cases identified through the interview/intake process at each medical center when the preregistration cases are caught up. This Unit also pursues any

"investigation" cases forwarded to them by the Preregistration Unit, in which the patient had a good employer known to have insurance coverage, but the patient did not share the insurance information with the Preregistration Clerk. During the months of June, July, and August, 2001, the VISN 5 Insurance Verification Unit verified and loaded over 3,300 new insurance cases for the medical centers within VISN 5 that had been identified through the preregistration and the interview/intake processes.

Martinsburg is fortunate in that we have a very knowledgeable, conscientious, experienced, and aggressive Collection Unit. The Collection Unit is responsible for all follow-up activities on third-party claims. The Unit reviews each explanation of benefits from the insurance carriers to ensure that we have been paid the correct and maximum amount according to the policy benefits, that all deductibles and coinsurance are appropriate, that any additional information required to adjudicate a claim is provided timely, and if the claim has been denied, that the denial is legitimate and according to the insurance carrier policy guidelines. If there is any question that we have not been paid appropriately or that the claim has been denied without justification, a call is placed to the insurance carrier for clarification of the policy benefits and explanation of exactly why the claim was denied. The Accounts Receivable Assistants (ARA) within the Collection Unit are assigned specific insurance carriers and become the "experts" on those insurance carrier benefits and idiosyncrasies. Each of the ARAs is very persistent and assertive. They will exhaust all means to obtain valid payment. If the information that one insurance representative provides does not seem in line with the known policy benefits, the ARA will call the insurance carrier at a later date and talk with a different representative. The ARAs have become familiar with Medicare billing regulations and guidelines, and what is covered under Medicare. The ARA loads all insurance carrier information into the specific insurance carrier/patient file and updates that information as necessary. The Collection Unit is responsible for identifying errors, omissions, duplications, and inconsistencies in claims generated, identifying inefficiencies in the collection process resulting in an inability to collect funds, and correcting and improving these processes or policies resulting in appropriate maximum payment on claims. They

communicate this information to the Coding/Billing Unit in an effort to ensure only good clean claims are generated.

The Collection Unit has a proactive MCCF/Utilization Review (UR) Clinical Coordinator who is a Registered Nurse. This incumbent of this position is responsible for contacting the insurance carriers and performing precertification, providing clinical concurrent reviews and case management, and appealing denied claims. The MCCF/UR Clinical Coordinator has been trained in most of the processes of the revenue cycle. The incumbent of this position has the expertise to perform many of the functions of the revenue cycle. This may include, but is not limited to, calling the insurance carriers to verify insurance coverage, conducting precertification, providing clinical reviews, explaining the billing process to patients and resolving their reimbursable insurance, as well as Means Test billing questions. The incumbent also provides training on reasonable charges and the importance of complete/accurate medical record documentation to the clinical staff. The MCCF/UR Clinical Coordinator works closely with the UR nurses and the Quality Management Section, identifying system issues which ultimately impact our MCCF Program, resulting in increased reimbursement.

Contained within the Collection Unit is the Health Benefits Advisor (HBA) position. The incumbent of this position reviews all inpatient admissions from the previous day. The purpose of this review is to identify insurance cases that require verification of coverage and benefits, to conduct insurance verification, and to identify those insurance cases requiring precertification. The HBA investigates possible insurance coverage on patients that have not been identified as having insurance coverage, and reviews admission diagnoses to identify any possible tort feasor or workers' compensation cases. On a monthly basis, the HBA reviews the top 100 diagnoses list to identify any possible tort feasor or workers' compensation cases. In Fiscal Year 2001, the HBA has identified 34 new insurance cases through this review that had not been identified previous to admission to the hospital. As a result, the insurance carriers were billed for the inpatient stays and the medical center did not receive a precertification penalty.

The medical center Director has a strong commitment to ensure MCCF collections are maximized. This commitment is communicated to the medical center staff through staff meetings, the monthly newsletter, and inservice training. Employee support and commitment is evidenced by the medical center exceeding MCCF collection goals for the past three years.

Mr. Chairman, this concludes my statement. I will be pleased to respond to questions from the Subcommittee.

STATEMENT OF
CATHLEEN C. WIBLEMO
ASSISTANT DIRECTOR, RESOURCE DEVELOPMENT
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
MEDICAL CARE COLLECTION FUND

SEPTEMBER 20, 2001

Mr. Chairman and Members of the Subcommittee.

The American Legion is pleased to have the opportunity to submit a statement for the record on the progress being made by the Department of Veterans Affairs (VA) to improve its financial management regarding third-party payer collections and contracting out initiatives.

The Balanced Budget Act of 1997, Public Law (P.L.) 105-33, established the Medical Care Collections Fund (MCCF). The MCCF is a depository for third-party insurance, outpatient prescription co-payments and other related medical collections and user fees. The funds collected and deposited into the MCCF may be used only for providing VA medical care and services during any fiscal year and for VA expenses for identification, billing, auditing, legal, and collection of amounts owed the government. As an added note, much to The American Legion's chagrin, the MCCF collections are used as an offset to the appropriations for the medial care budget rather than a supplement. These collections are for the treatment of nonservice-connected medical conditions; therefore, should supplement the annual discretionary appropriations, which covers the cost of medical care authorized to certain veterans in priority categories 1-6. Logically, MCCF is reimbursement for the treatment for which annual discretionary appropriations is not intended. The American Legion continues to adamantly oppose offsetting annual discretionary appropriations by the MCCF recovery.

P.L. 105-33 also established VA's authority to begin billing reasonable charges for the provision of nonservice-connected conditions (implemented by VA in September 1999). Reasonable charges are comparable to charges used in the private sector for the same services in a specific geographic area. Prior to this, VA used cost-based per diem rates for billing insurers. With the authority to bill reasonable charges, VA's collections have increased. To date (FY 2001), VA has collected over $708 million, an increase of 38 percent over last fiscal year, and predictions is that in FY 2005 to collect $1.4 billion. Although this sounds like good news, The American Legion notes that this amount could be even higher if VA was granted the authority to bill Medicare directly, either on a fee-for-service basis or under the Medicare+Choice option.

Currently, approximately 70 percent of the health insurance policies reported are Medicare supplement policies. Under current law billing on a fee-for-service basis, VA can expect to collect only 20 percent of the billed amount – the Medicare-eligible veteran is

responsible for paying the remainder of the bill. When a veteran does not have Medicare supplement coverage, the veteran is obligated to pay the entire bill, even if Medicare normally covers the care in the private sector. The amount expected from billing these supplemental policies is much less than if the VA was allowed to bill Medicare directly under the fee-for-service option.

The American Legion fails to understand why VA, unlike Indian Health Services (IHS), cannot participate in Medicare subvention. Eligibility for enrollment or treatment in IHS is based on solely birth. ***Medicare-eligibility is not a condition for enrollment or treatment in IHS.*** Eligibility for enrollment or treatment in VA's health care network is based on honorable military service. ***Medicare-eligibility is not a condition for enrollment or treatment in VA's health care network!*** Therefore, The American Legion fails to understand why VA cannot participate as a health care partner with the Centers for Medicare and Medicaid Services (CMS).

The American Legion strongly advocates CMS allowing Medicare-eligible veterans to exercise their **fee-for-service** or **Medicare+Choice** options. Under the fee-for-service option, VA would only seek reimbursement for the treatment of nonservice-connected conditions for enrolled Medicare-eligible veterans. The American Legion believes VA would readily accept CMS' reimbursement rate for Medicare-eligible patients.

Under the Medicare+Choice option, The American Legion believes that Medicare-eligible veterans would be willing to participate and chose VA as their primary health care provider. Clearly, Medicare+Choice is beneficial to CMS and VA. Medicare+Choice places Medicare-eligible patients into integrated health networks – far more cost effective than the fee-for-service option.

The American Legion reaffirms its opposition to CMS denying Medicare-eligible veterans financial coverage solely because Medicare-eligible veterans choose to enrollment and treatment in the VA health care network, as opposed to seeking care elsewhere. Currently, fewer Medicare beneficiaries cannot exercise their Medicare+Choice options because more and more health care providers are refusing to participate. Yet, The American Legion is urging CMS to allow VA to fill that void. Based on the quality of health care provided by VA, based on CMS' own performance standards, is outstanding. Medicare-eligible veterans and their families would be well served should CMS allowed VA to serve as a Medicare+Choice option.

Billing reasonable charges has created myriad problems for VA as they struggle to streamline the revenue collection process. Itemizing of services on a claim form is labor intensive and to do it efficiently and effectively requires a highly trained staff. Also, VA was not prepared for the scrutiny of the insurance payers to ensure correct billing and compliance with standardized forms and codes. Furthermore, the Veterans Health Administration's (VHA) information system is not configured to handle patient accounting and does not provide the required features and functionality needed to accurately capture data.

In May 2001, Secretary Principi directed the Undersecretary for Health to develop a revenue cycle improvement plan. That plan was delivered in September 2001 and addresses several of the problems confronting VHA for the last four years.

Current Cycle Performance

The revenue cycle effectiveness is measured by specific performance measures. Seven measures have been identified by VHA and compared to private sector performance measures. Private sector benchmarks have been used where applicable.

Percentage of Complete Registrations – Only 58 percent of the medical centers performed in the top tier of performance, which is 100 percent to 80 percent complete registrations, as compared to 82 percent of the private sector.

Percentage of Insurance Policies Verified- VHA performed at a high level of effectiveness for insurance verification, with 94 percent of Veterans Affairs Medical Centers (VAMCs) performing in the top tier of performance, which is 93 percent to 100 percent insurance policies verified. The one drawback to this is that VHA has no national standard for the timeliness of verification. Therefore, VAMC insurance databases may have old verification information in them.

Number of Days for Inpatient and Outpatient Bill Lag – Forty-one medical centers, or 31 percent, performed in the top tier of performance for inpatient services, or 16 to 40 days lag time. Outpatient services were even less than that, with 24 percent of the VAMCs performing in the top tier of performance, or eight and 90 days lag time. Private sector benchmarks for this performance measure are five days for inpatient and six days for outpatient.

Percent of Receivable Dollars Greater than 90 Days Old - This amount represents the monies that have not been paid by the insurance carrier. There is a significant difference in the private sector, at 29 percent and the VHA total at 49 percent. While VHA's percentages have been adjusted due to their inability to bill Medicare, which accounts for 70 percent of their outstanding accounts receivable, the percentage is still very high.

Percentage of Collection Dollars to Billed Dollars- VHA's collection rate is 35 percent.

Collections – VHA has seen an increase in collections with total collections improving by 25 percent in FY 2001.

The American Legion as part of its National Field Service site visits to the VISNs and their medical center components examines data related to MCCF. In particular, the amount of collections and the timeframes to generate billings and make collections. It is not surprising that the feedback mirrors the shortfalls shown in the performance measurements. Data obtained this year was cumulative for FY 2000 and showed that most facilities met or exceeded their collection goals. However, the average times to generate an outpatient bill were quite varied and in numerous cases, they were extremely high. Health Care Systems in VISN 22 reported average times as high as **165 days**, and **183 days**, while medical centers in VISN 9 reported times of **120** and **158 days**. Facilities in VISN 4 reported processing times of 100 and 187 days. In contrast, some medical centers were able to generate bills in 50 to 60 days with the lowest reported

average time in a 20-day range. The combined average time to generate a bill and collect a payment typically approached 6 to 7 months.

It was noted that often there were large amounts (millions of dollars) of past billings in litigation. This appears to be the result of contested bills where carriers are secondary payers to Medicare. Some insurance companies have held off paying Medigap payments of Medicare-eligible veterans because VA is not an authorized Medicare provider and there is no Explanation of Benefits for Medicare on the claims. The American Legion believes resolving this problem could result in collections of about 20 percent of the amounts billed.

In discussing the above data during site visits, VHA facilities have been making efforts to improve their business processes for billing and collection. The American Legion believes VHA is very cognizant of its need to improve. Some facilities experience problems competing for or retaining essential personnel, such as coders. Others are very interested in pursuing remedies, such as electronic billing. However, this can be a resource issue in competing for scarce dollars. VHA also faces challenges in addressing waits and delays for clinical treatment that must be addressed.

Veterans have often shared their perspective on MCCF with The American Legion through their correspondence. Those who write are often frustrated in understanding the process and have difficulty differentiating between third-party reimbursements and co-payments. They are dismayed by the long gaps between treatment times and when they are actually billed. A large percentage of veterans are also concerned about their liability. Continued outreach is needed to better educate veterans on MCCF.

The Revenue Cycle Improvement Plan seeks to overhaul the way VHA does business. The plan lists 24 critical actions that need to be accomplished in the short term. These 24 actions all have a timeline attached to them and the office responsible for ensuring completion of the action. The long-term solutions include consolidation and outsourcing. The American Legion is not opposed to the outsourcing of billing and accounts receivable functions, as well as the patient financial/accounting system. The VA spent approximately $120 million in FY 2000 on billing, coding, collections, documentation and claims. However, The American Legion would caution that VA's contracting performance in the past has been less than stellar. The American Legion, through its National Field Service site visits, learned that in some cases contracts have been poorly written and have resulted in additional expenses and lack of control.

While generally pleased with the Revenue Cycle Improvement Plan, The American Legion is frustrated at the extension of the process to nearly 2004. We are also somewhat skeptical that the proposed timelines will be adhered to.

The American Legion commends VHA for the progress it has made in some of these areas over the last four years. However, The American Legion remains concerned with the amount of time VHA has taken to reach this point, with yet another extended timeline proposed to fix these problems.

Mr. Chairman, that concludes my statement.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
SEPTEMBER 20, 2001

Mr. Chairman and Members of the Subcommittee:

On behalf of the more than one million members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF) program.

The subcommittee indicated it would focus this hearing on examining the progress being made by the VA to improve its financial management regarding third-party payer collections. In 1986, Congress authorized legislation giving VA authority to bill private insurers for care provided to insured nonservice-connected veterans. In 1990, this authority was expanded to allow VA to collect for the treatment of nonservice-connected conditions of insured service-connected veterans. In 1997, Public Law 105-33 established the current MCCF and authorized VA to retain all collections from insurers as well as other revenues such as veterans' copayments and deductibles. Before the MCCF was established, VA was allowed to keep only enough collections to cover administrative collection costs and was required to deposit the remainder in the U.S. Treasury. This law also granted VA authority to begin billing reasonable charges versus reasonable costs for care. Reasonable charges are based on the amounts that insurers pay for the same care provided by private industry health care providers in a given geographic area.

The DAV, in concert with the *Independent Budget*, believes that it is the responsibility of the Federal government to fund the cost of veterans' health care. Therefore, we urge Congress to provide a sufficient medical care budget fully funded by appropriations. Although the VA has the legal authority to collect third-party payments for certain types of care, Congress should consider any funds derived from third-party collections as a supplement, not a substitute for appropriations. In the same vein, we are opposed to Congress and the Administration, using collections or projections of collection, to reduce appropriations.

Although VA has attempted to implement more effective billing practices and systems, it has historically been unable to meet its collection goals. The Government Accounting Office (GAO) reported in September 1999 that:

> In fiscal year 1995, VA collected $523 million from third-party insurers. Since then, the amount collected has declined every fiscal year and may decline again in the current fiscal year. Collections declined from $523 million in fiscal year 1995 to $495 million in fiscal year 1996, $450 million in fiscal year 1997, and $442 million in fiscal year 1998. As of August 31, 1999, VA had collected $388 million during fiscal year 1999. VA's average collections are about $35 million per month, but it will have to collect $54 million in September to equal fiscal year 1998's collections.

VA in fact did not meet its collection goals for fiscal years 1999 or 2000. We do however recognize that VA has made a concerted effort to improve financial management of third-party collections and that it has made some progress in this area since the last GAO report. Unfortunately, there are still many weaknesses in the program, and we believe much more needs to be done to improve billing and collections procedures. The VA Medical Administrative Service (MAS) personnel we contacted concerning this issue agreed that VA has made some headway since the inception of the program; however, they report that many facilities still have fundamental problems with patient intake, medical documentation, coding, and billing procedures. Disturbingly, we also continue to hear reports from service-connected disabled veterans indicating that VA is billing their insurance company for treatment of service-connected

conditions. One DAV member stated he has repeatedly contacted the local VA facility concerning this problem, but it continues to happen.

GAO reported in its September 1999 report on VA medical care collections that:

> Having accurate information on third party insurance, such as the type of policy and the types of services covered, patient copayments and deductibles, and preadmission certification requirements, is key to VA's MCCF program. Yet only 54 percent of VA facilities reported that their collection of health information was thorough by June 1999.
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> . . . .
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> VA's ability to accurately document the nonservice-connected care provided to insured veterans and assign the appropriate codes for billing purposes is essential to Veterans Health Administration's (VHA's) third-party collections program. VA can bill only for nonservice-connected care, and VA staff told us that sometimes the explanations provided for veterans' service-connected disabilities are not specific enough to help physicians determine whether the care they provide is related to service-connected conditions. About 20 percent of medical facilities did not report having procedures to validate whether treatment was for a nonservice-connected disability, and less than 70 percent had reported that they trained their staffs in converting the explanation of care provided into codes used to bill insurers.
>
> Failure to properly document care can lead to missed opportunities to bill for care, overpayments by insurers, or denials of VA bills.

DAV wholeheartedly concurs with these findings. Additionally, VA field representatives we interviewed concerning the MCCF program confirmed these and other challenges.

Initially, sources pointed out that collecting accurate and complete information during the intake or interview process is key to all other components of the billing process. Therefore, it is most important that proper intake of insurance and other information is collected prior to or during the veteran's initial visit to the medical facility. They stressed how essential training was for administrative personnel and reinforcing the importance of gathering accurate and complete information from the veteran. We understand however, that these positions are rather low paying and that there is frequent turnover of these staff members who often seek better opportunities within the system. VA personnel also stressed the importance of continuing education as updates and changes occur in the system. They recommended that information be simplified so that administrative staff, clinicians, and veterans can understand the process and information provided.

Secondly, sources noted that following specific coding procedures and proper medical documentation of treatment by physicians are essential components to accurate billing. Inaccurate coding is likely to result in delayed or denied payment of claims for services rendered. VA personnel reported there is still a high rate of coding errors based on insufficient medical documentation and noted what complicates this matter is that physicians are often not properly trained and do not understand the importance of this step in the billing process. Additionally, they stated that clinicians frequently rotate in and out of the system and unlike the private sector are not held accountable for administrative infractions. There is little incentive for VA physicians to properly document treatment rendered unlike in the private sector where physicians who routinely neglect to record proper medical information don't get paid for the services they provided. There is no penalty or reward system in place in VA to encourage physicians to comply with proper documentation procedures.

Finally, MAS personnel noted that information technology issues are a critical component and that upgrades in information systems and software are necessary to streamline the process. They recommended that existing technology be upgraded to ensure all elements of the collections process are fully integrated. Sources also pointed out that having to follow-up with insurance companies is often time consuming and causes a burden on limited staff. Clerks

are needed to perform many duties and often this step is turned over to a contractor. However, even with a contractor providing this service, staff routinely must finalize the process, simply creating another type of workload.

In conclusion, as funding shortfalls continue for veterans' health care, it is important that these and other problems associated with the collection of third party payments be resolved. The VHA must address these areas of concern in order to improve the MCCF program and ensure timely, accurate billing for third party collections. VA must develop a sound plan to effectively manage all aspects of the collection process and resolve weaknesses in the current program. Facility leadership and staff must comply with established policies and procedures and be held accountable for deficiencies. It is vital for VA to set standards and find a way to effectively disseminate information. Control and quality of information along with continued support of the program and oversight is key to solving many of the problems plaguing the MCCF program.

Clearly, VA faces many challenges concerning its fiscal responsibility and management of the MCCF program. Although we have shared our concerns about some the weaknesses of the MCCF program and recommended improvements, we remain focused on sufficient appropriations for VA health care. We urge this Subcommittee to address the medical care appropriations in a straightforward manner by providing a realistic and adequate budget fully funded by appropriations. The Federal government should not rely on collections from veterans and their insurers to meet the nation's obligation to provide veterans' health care. Any third party collections secured by VA should be a supplement to, not a substitute for, appropriations. Finally, we would like to note for the record that delegates to our last National Convention in Miami Beach, Florida, July 28-August 2, 2001, passed DAV resolution No. 218 which calls for legislation to repeal all copayments for veterans' medical services and prescriptions.

The DAV sincerely appreciates the Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's veterans. Thank you for the opportunity to present our views on the VA's MCCF program.

STATEMENT OF

SIDNEY DANIELS, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES
TO THE

SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE COLLECTION FUND

WASHINGTON, DC SEPTEMBER 20, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

The Veterans of Foreign Wars appreciates the opportunity to submit a statement for the record on our concerns regarding the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF). The MCCF, as we know it today, has evolved from a series of laws and policies over the last fifteen years.

In 1986, Congress provided the initial authority to the VA to seek reimbursements for medical services from private insurers who covered non-service connected veterans. Congress later expanded VA's authority, making it possible for the agency to also bill third-party insurers for medical services provided to service connected veterans who received treatment for non-service connected conditions. Subsequently, under provisions of the Balanced Budget Act of 1997, the VA was granted authority to create the MCCF and to retain all reimbursements it received, including co-payments, and deductibles paid by some insured veterans based on a formula that takes into account household income and the veteran's ability to pay.

Since income collected through MCCF offsets or reduces VA's appropriated health care funds by an identical amount, it is therefore essential that the MCCF operate at an optimum level. All income collected through the MCCF is reprogrammed and ultimately

used to provide medical care to veterans and to meet the expenses associated with collection activities.

Although the VA developed a reasonable five-year plan in 1997 that was designed to bring in 10 percent of its funding from the MCCF, this goal was not achieved. The General Accounting Office (GAO) noted in its 1999 review that VA collected $523 million in Fiscal Year 1995 from third-party insurers. Collections continued to decline for each successive year through Fiscal Year 1999 when the agency brought in only $388 million.

The GAO reported that several key factors played roles in hindering VA from achieving its goal. First, a significant number of older veterans reached the age of 65 and became Medicare eligible. By law, Medicare cannot pay for services provided by VA, contributing to VA's lost revenue.

Second, GAO found that more veterans were enrolling in Health Maintenance Organizations (HMOs) and other managed care plans. Based on VA's own data, General Population enrollments in HMOs increased from 25.8 to 58.8 million from December 1986 to January 1997. Because VA was not a participating managed care provider, it again suffered a loss in revenue.

Third, VA's shift in emphasis from inpatient care to less expensive outpatient care resulted in many more veterans being treated on a less-expensive outpatient basis, which also has the effect of bringing in less revenue for medical services provided.

It is the view of the VFW that given the factors cited by GAO for the decline in third party collections, VA could have done a better job of limiting those declines had the agency implemented stronger management practices.
Good management practices require being fully aware of developing trends that impact the health care industry, income streams, and making the necessary adjustments to

compensate for those changes. We believe that VA could have been more proactive in identifying the significant increase in the number of veterans who became Medicare eligible along with those who opted for treatment through HMOs. The agency should have reported this potential loss of income to Congress on a timelier basis. In addition, we believe that VA could have been more proactive in identifying alternative income streams, particularly since new authority to collect payments from Medicare has been considered by Congress and subsequently denied.

The VFW believes that a major attraction for insured veterans who seek treatment through HMOs is the speed with which they are able to make an appointment and receive treatment. We feel that a substantial number of insured veterans would seek treatment with a VA facility if the time that it takes to make an appointment and receive treatment could be improved.

For example, it currently takes a veteran seeking an Agent Orange protocol examination over one year to see a doctor. Such a lengthy waiting period does not speak favorably for quality health care and is not likely to influence insured veterans, who have other options, to utilize the VA health care system.

Mr. Chairman, the VFW is particularly concerned about how VA collection activities affect insured veterans and those subject to co-payments.
Currently, the VFW tracks the concerns of veterans in 110 issue areas through our Tactical Assessment Center (TAC) in Washington, DC. With the cooperation of VA, posters with our telephone number (1-800-839-1899) are prominently displayed in all VA medical centers and outpatient clinics. Veterans nationwide are able to contact us concerning a host of programs and services that are available to them through the VA, to discuss any problems that they may have in accessing those services, or issues relating to the quality of services received. Since inception of the TAC four years ago, we have received over 41,000 telephone calls from veterans with 1,354 of those inquiries involving co-payments.

Among the key concerns voiced by veterans is the failure of some VA medical facilities to bill the veterans' insurance company on a timely basis. Consequently, many veterans are receiving co-payment bills before their insurance company has been billed. Since the insurance company's payment normally reduces the veterans' out-of-pocket expense, the veteran is forced to pay more than he should, clearly creating an extra burden on the veterans. Further, when the insurance company makes its payment to VA, many veterans complain that they are required to wait months for the corresponding refund.

While we acknowledge that several Veterans Integrated Service Networks (VISNs) have taken positive steps to correct the problem—such as extending the veterans billing hold period to 120 days—we feel that this alone will not solve the problem. It is our view that additional VA staffing and training is also needed to meet the present demand.

An additional contributing factor to the MCCF billing problem is that the coding of patient medical records for billing purposes is backlogged throughout the entire health care system. These codes inform the insurance companies what procedures were performed and the problems diagnosed so the insurance companies can provide the appropriate professional charges on the patient's bill. Since these codes are not being provided in a timely manner, the billing system lags behind. Until additional staff is trained and more coders are certified, the system will continue to be backlogged.

The VFW has also observed problems with Accounts Receivable collections. There are millions of dollars that have been billed, but not yet received. At a recent visit to one VA facility in Lebanon, Pennsylvania, a VFW representative observed that there were over 6,500 unbilled issues totaling over $5 million at this one facility alone. It is our view that VA must provide better employee training on billing issues and on how to be more assertive when seeking payment from insurers.

Mr. Chairman, this concludes our statement for the record and the VFW would like to thank the Committee for holding a hearing on this most important issue.

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Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the Record

By

Philip A. Litteer
Chairman, National Government Affairs Committee

And

Patrick G. Eddington
Associate Director of Government Relations

Before the Subcommittee on Oversight and Investigations

House Committee on Veterans Affairs

Regarding

The VA's Medical Care Collection Fund and related issues

September 20, 2001

Mr. Chairman and other distinguished members of the Committee, Vietnam Veterans of America (VVA) is pleased to have this opportunity to provide our comments for the record on our concerns regarding the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF) and contracting issues within the VA.

As you know, in 1986 Congress authorized the VA to begin receiving third-party payments from insurers who covered non-service connected veterans. In 1990, Congress subsequently expanded the VA's authority to bill for medical care provided to insured service-connected veterans, provided the treatment was for a non-service connected condition. The Balance Budget Act of 1997 further revised the system to allow the VA to retain all third-party reimbursements, and created a specific fund for this purpose, the Medical Care Collection Fund (MCCF). MCCF monies can be used to fund both medical care collection activities and to provide health care services to veterans. Through the MCCF, the VA is allowed to bill insurers at market rates.

The VA has, as part of its overall strategic plan, repeatedly told the Congress that it has a goal of generating at least 10% of its funding from "alternative revenue streams," a euphemism for the MCCF and the deductibles and co-payments charged to Category 7 veterans. The VA has never reached this goal due to a number of factors.

First, VA has an abysmal track record of collecting from private insurers. As GAO reported in 1999, VA collections from insurers declined in every fiscal year from 1995 through 1999 (the last date for which VVA has figures). From a peak of $532 million in 1995, VA third-party collections declined to roughly $400 million by the end of fiscal year 1999. VA has even had to retain a private contractor to help it collect on delinquent bills. This is clearly a case of gross mismanagement at the VA, and we sincerely hope that today's hearing will serve as a wake up call for senior VA leaders where this aspect of the MCCF problem is concerned. Although collections to MCCF this year are up significantly, the cost of collecting these payments still makes this a marginal source of revenues. Part of the problem is that it is clear that the Office of Management & Budget (OMB) "discounts" the Veterans Health Administration budget request by the amount in collections anticipated, making the collections a wash in terms of bringing more revenue into the health care system.

Additionally, VA's shift from an inpatient-based to an outpatient-based health care model has dramatically reduced the number of opportunities to bill insurers for medical services; outpatient treatment episodes are almost always lest costly than inpatient encounters. GAO reported in September 1999 that the annual number of VA inpatient episodes dropped by more than 250,000 between 1995 and 1998, while the number of outpatient episodes climbed by nearly 7 million.

VVA does not at present have figures on the numbers of outpatient encounters involving over-65 veterans. We would suggest to the committee that this is an area requiring further study and investigation, because another key problem facing the MCCF—and one completely outside of the VA's control—is the aging veteran population. An increasing number of veterans are over

65 and thus Medicare eligible. At present, however, there is no Medicare subvention program available to the VA through which the VA could bill Medicare for veteran's health care. Because the VA is not an authorized provider under any existing HMO plan, VA cannot bill those plans for services provided to veterans.

This issue is becoming more acute due to the VA's Capital Asset Realignment for Enhanced Services (CARES) process. In essence, CARES serves as a vehicle for the VA to shut down aging medical centers, shift functions and services to more modern facilities, and expand the number of community based outpatient clinics (CBOCs) within the VA system. We have testified before the full committee on previous occasions about our growing concerns over the decline in access to VA health care for hundreds of thousands of veterans across America.

On September 17, VVA filed comments with the VA opposing their proposed CARES-driven reorganization of VISN 12 primarily because of the VA's refusal to contract for medical service for veterans living in regions not within an easy drive of a VAMC. Similarly, the VA's inability to bill Medicare for services compromises health care for elderly veterans by tying over-65 veterans to VAMCs that are often hours from their homes. These issues are closely linked, and as such require a comprehensive Congressional response.

Reestablishing effective health care for veterans is VVA's number one legislative priority, and to that end, we would like to offer our suggestions on how the Congress should approach the MCCF issue in the broader context of veteran's health care.

To help deal with the immediate problem of inadequate management oversight of the MCCF overdue bill account, the Congress should mandate that the Secretary of Veterans Affairs provide an annual report on the status of overdue bills. Moreover, Congress should pass legislation that levies a $10,000/day fine on any insurer who is more than 90 days in arrears to the VA. We are confident that such punitive measures would quickly incentivize private insurers to settle their accounts with the VA.

Secondly, the VA must do a better job of collecting insurance information from veterans in order to properly charge for services billed. GAO has repeatedly found the VA deficient in this area, and only strong management action will likely correct the problem.

Third, it appears that at least some insurers continue to use exclusionary clauses denying payment for care given at VA facilities. Our understanding is that there is no legal basis for any insurer to make such stipulations, and accordingly, Congress should pass legislation to ban such practices by insurers and to institute severe financial penalties for insurers who attempt to continue such practices.

Fourth, the VA must be compelled to make its diagnostic and billing systems compatible with those used in the private sector. Too often, GAO has reported that insurers have denied payment because of questions about the medical necessity of VA procedures; some of these denials are the result of the VA providing inadequate billing details to the insurer. The VA must

be brought into compliance with the wider health care industry where billing issues are concerned if these problems are to be eliminated and recoveries increased.

Fifth, the Congress must examine the MCCF issue in the broader context of veterans' declining access to quality health care. Although Medicare subvention for VA might address some of these issues in the short to medium term, a recent Department of Defense (DoD) Medicare subvention pilot project offers some insight into potential problems and limitations that any VA Medicare subvention program might encounter.

When it began its Medicare subvention pilot program in 1998, DoD had no experience dealing with the guidelines established by the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration or "HCFA"). It took DoD more than a year to actually get the program off the ground; once the program was in place, however, it was generally successful at all of the demonstration sites, according to GAO.

DoD officials involved in the pilot projection admitted to GAO that HCFA/CMS standards forced participating sites to improve their medical record keeping and adopt some important "best practices" from the private sector. Accordingly, there is reason to believe that the VA could benefit in a similar fashion from such a program.

At least one problem encountered in the DoD Medicare subvention pilot—military medical staff turnover and deployments—would not in all likelihood affect the VA system. Other problems—such as the reluctance of providers to accept rates that are lower than the out-of-network rate they could otherwise receive—would likewise plague a VA Medicare subvention effort. Additionally, veterans may still face problems of distance to providers for certain specialized services even under a subvention scheme.

Our view is that the true solution to reestablishing effective health care for veterans requires a) adequate funding for the existing VA health care system, and b) effective use of contract medical services for veterans living in rural or other remote submarkets. In our comments to the VA regarding its proposed reorganization of VISN 12 via the CARES process, we noted that as there is no VAMC in the region between Iron Mountain and Tomah, we found it incomprehensible that the VA would select options that do not *mandate* medical service contracting for the nearly 100,000 veterans who live in these two markets. We are certain similar situations exist across the country, and that therefore the need for contract medical services is real and growing.

Sixth, Vietnam Veterans of America (VVA) is concerned about the strong-arm collections techniques used on veterans who have legitimate claims that have been pending for years at the Veterans Benefits Administration. VVA knows of specific instances where veterans have withdrawn from needed treatment because of the seizure of tax refunds and damage being done to their credit rating. In the instances cited, VBA subsequently granted the claim, but the damage was already done. Not even an apology was forthcoming from VA.

Mr. Chairman, VVA suggests that Committee work with the VA to devise a way to truly develop and expedite claims where there is an MCCF payment problem that may well cause the veteran to drop out of vitally needed treatment. While we know that improving the quality and reducing the time a veteran has to wait for a fair and accurate determination on that veteran's claim is important, we have a very long way to go in many geographic area. In the meantime, it is clear that some sort of forbearance and expediting combination of actions is needed, if VA is to truly live up to the Secretary's mandate of "One VA."

Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these extremely important issues, and we look forward to working with you, Mr. Chairman, and your distinguished colleagues on this Committee to address and resolve these and other important matters of concern to our nation's veterans.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO RICHARD J. GRIFFIN

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

NOV 21

The Honorable Stephen E. Buyer
U.S. House of Representatives
Committee on Veterans' Affairs
Chairman, Subcommittee on Oversight and Investigations
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter dated October 26, 2001, requesting follow-up information to the House of Representatives Subcommittee on Oversight and Investigation's September 20, 2001, hearing on the management of the Medical Care Collection Fund. Our responses to your questions are as follows:

Question No. 1: Have there been any major differences in the findings of your current investigations compared to the findings of your 1998 audit report?

The major difference in the findings in our current audit involves the billing backlog issue. The Balanced Budget Act of 1997 (Public Law 105-33) authorized VA to bill reasonable charges for medical care provided on or after September 1, 1999. Reasonable charges are defined as amounts that insurers would pay private sector health care providers in the same geographic area, for the same services. According to VA, billing reasonable charges is more labor intensive and time consuming than billing cost-based per diems. In May 2001, VA began accumulating nationwide totals of unbilled amounts for inpatient, outpatient, and prescription charges in a monthly Unbilled Care Report. Prior to May 2001, unbilled care was only captured at the medical center level and was not rolled up nationally.

Question No. 2: When do you expect to issue your report on the current national audit?

We plan to issue our final report on the current national audit in January 2002.

Questions No. 3a – 3c: In your testimony you said that VA's Unbilled Care Report as of July 2001, shows a cumulative balance of $931 million.

(a) Is the balance increasing at a significant rate?

The balance has been increasing at a significant rate since May 2001, and as of September 2001 totaled over $1 billion. The nationwide balances and percentage of increase per month were as follows:

2.

The Honorable Stephen E. Buyer

NATIONWIDE BALANCES AND PERCENTAGE OF INCREASE PER MONTH

MONTH	BALANCE	% INCREASE
May 2001	$859,922,590	N/A
June 2001	$883,168,003	2.7%
July 2001	$931,426,012	5.5%
August 2001	$982,089,875	5.4%
September 2001	$1,052,660,528	7.2%

(b) Will this impact the VA's financial statement and the "unqualified opinion"?

This will not impact VA's consolidated financial statements and the unqualified opinion if the recorded balance for accounts receivable is accurate.

(c) How long has this balance been accumulating?

We do not know how long this balance has been accumulating as VA did not begin to accumulate nationwide totals of unbilled amounts for inpatient, outpatient, and prescription charges until May 2001. As stated earlier, prior to May 2001 unbilled care was only captured at the medical center level and was not rolled up nationally.

Thank you for the opportunity to respond to your questions. If you require additional information, please contact Mr. Michael Slachta, Jr., Assistant Inspector General for Auditing, at 202-565-4625.

Sincerely,

RICHARD J. GRIFFIN
Inspector General

Post Hearing Questions
Concerning September 20, 2001, Hearing
For the Honorable Thomas L. Garthwaite, M.D.
Under Secretary for Health
Department of Veterans Affairs
From Congressman Steve Buyer
Chairman
House Committee on Veterans Affairs
Subcommittee on Oversight and Investigations

Question 1: Our 1999 hearing focused on over-billing, inappropriate, or incorrect charges to third-party payers, please give us an assessment as to whether or not this is still a problem? If so, what has been the total dollar amount reimbursed to these third-party payers? How much money has been lost or not collected due to under-billing?

Answer: Instances of over-billing, under-billing, and inappropriate or incorrect charges submitted to an insurance carrier are situations that occur in any billing operation both in the private sector and within VA. Staff within VA and insurance carrier offices independently perform periodic data quality reviews on claims submissions. Identified errors are returned for correction.

United HealthCare, the fiscal intermediary for AARP, has been performing periodic audits of VA's claims. Since 1997 to the present time, they have reviewed claims submitted from 40 different VA health care facilities. A total of $3.9 million has been repaid to AARP for identified overpayments. This is the only insurance carrier that has been actively involved in this type of claims review dealing with numerous VA health care facilities.

Our data systems do not allow us to provide specific information regarding money lost or not collected due to under billing. However, we are working with VISN 12 to determine the number and dollar value of professional claims for inpatient services that were not billed for a specified number of discharges. As a part of this project a contractor is reviewing the medical record for all included cases, coding the billable professional services, and VISN 12 staff is billing for the services. This project will (1) determine the under billing of these services for the inpatient episodes reviewed, (2) project the collections anticipated from the claims, (3) further project the unbilled professional services for the entire VISN based upon the sample completed and (4) project on a national level the lost revenue due to unbilled inpatient professional services. A cost benefit analysis will also be done to determine if contracting out the medical record review and coding for inpatient professional services would increase revenue for VHA after all contract services have been paid.

Question 2: In the General Accounting Office's (GAO) testimony, it said that it takes the VA fourteen times longer to bill a third-party payer than the private sector. Can you tell me why this is the case?

Answer: We believe that two factors influence the discrepancy between the private sector and VA's billing time. First, as part of our efforts to prevent the appearance of fraudulent insurance billing, VA validates Current Procedural Terminology (CPT) codes prior to releasing a bill. This produces a backlog in the coding process that delays production of a bill. To address this, VA medical centers (VAMCs) contracted with private sector firms to assist with medical coding, and we have intensified efforts to train staff on proper coding and revenue cycle procedures. VA recently contracted with PriceWaterhouse Coopers for a review of our Revenue Office, and we are in the process of implementing a wide range of recommendations from that study that will address this concern.

Second, VA's computerized information system was initially established as a patient "treatment" database rather than a "patient account" database. The VA Capital Investment Board is considering a proposal for a commercial software package more in line with a "patient account database."

Question 3: In reviewing the Inspector General's (IG) testimony it is very apparent that the VA has made very little progress in implementing the goals it set for itself at our 1999 hearing. The Combined Assessment Program Reviews show that overbilling and underbilling, coding errors, and inaccurate documentation are still prevalent in many Veterans Integrated Service Networks (VISN). In fact, about half of the 570 outpatient visits reviewed, contain coding errors. Why is it that two years later the VA is still experiencing the same problems they promised to fix at our last hearing?

Answer: When VA converted to reasonable charges September 1, 1999, facilities were faced with creating multiple claims depicting professional fees and institutional fees for inpatient as well as outpatient episodes of care. Under the previous billing system, one claim was submitted for all fees, and outpatient coding was not an important process for reimbursement. Medical center personnel were actively involved and trained in the inpatient coding process and had little or no experience with the coding system for outpatient coding. Medical center staff had to obtain the skills necessary to accurately code the services provided on an outpatient basis. The new billing requirements under reasonable charges required additional documentation by the clinical staff. This prompted medical centers to develop new encounter forms or to update the encounter forms currently being used to provide the data items necessary for coding and reimbursement. Clinical staff also had to learn new documentation skills to accurately depict the services that were provided to the patient during the outpatient encounter. Many medical centers obtained coding and documentation training for their administrative and clinical staffs to meet the new demands. VA also recognized that a compliance program needed to be established to advise, audit, and promote good business practices. Therefore, the VHA Office of Compliance & Business Integrity (CBI) was created.

The CBI has initiated a nation-wide monitoring and auditing system. Included is weekly quality monitoring of business program output (statistically valid sampling) of the

accuracy of diagnostic and procedural coding of clinical encounters as well as the accuracy of bills submitted to veterans (first-party bills) and to third-party payers (third-party bills). This allows VISNs and VAMCs to accurately assess efforts to mitigate coding errors.

Additionally, the system will provide monitoring of Explanation of Benefits (EOBs) received from third-party payers to assess first-run yield (the percentage of claims paid by the third-party payer the first time the claim was submitted) and the reason for claim rejection.

Health Information Management has reported significant shortfalls in the number of qualified and certified coders that VHA has been able to hire. The same problem exists in the private sector. This impacts volume, quality, and timeliness of coding efforts.

Question 4: The report submitted to the Subcommittee for this hearing was very similar to the one that was presented for the 1999 hearing. The aim of this hearing isn't to find fault, but it appears that the VA is at a standstill when it comes to correcting the management problems and built-in inefficiencies that exist. I would like to ask you how these two plans differ. Also, how much did it cost the VA to have these two reports produced?

Answer: The total cost of the study completed in FY 2001 was $335,000. The cost of the study completed in FY 1998 was $633,542. Below is an analysis comparing the two reports that were completed on the Revenue Program.

Subject	1998	2001
Pre-registration	Pre-registration utilized at only six sites. Pre-registration is a sound activity that can significantly help identify and retrieve patient insurance information	Mandate pre-registration of veterans. Private sector considers pre-registration process an integral practice within high performing organizations. Besides reminding a patient of an upcoming appointment, pre-registration process enables VHA to verify and/or update current demographic and insurance information.
Insurance Identification	Insurance identification lacks aggressiveness. If the veteran answers no to the insurance question, no follow-up questions are asked. Currently insurance verification is a labor-intensive process. Manual insurance verification often increases the time and cost to produce a bill.	Implement electronic insurance identification and verification. There are now products available specifically designed to verify patient insurance information electronically. This would allow VHA to verify veteran's coverage and policy type via on-line electronic connectivity.

Subject	1998	2001
Patient Registration	Intake personnel are not properly trained in interview techniques and customer service issues. Intake staff at any VA medical centers is not knowledgeable about other MCCR processes and goals.	Develop and implement VHA employees education program. VHA employees that are knowledgeable with understanding of the underlying rationale behind requirements, facilitate and enhance not only the data capture process but the patients and employees communication and interaction. The expected outcome will be VHA employees who understand and value the importance of collecting data from their patients during the registration process.
Software & Technology	Software and technology are not being utilized to optimum levels. For instance, clean insurance databases would increase data accuracy and process efficiency.	VHA is at an information system disadvantage as compared to private sector hospital systems. While improvements in the information system will not achieve collection goals by itself, the current applications that support the revenue cycle are not adequate to support the VHA long-term vision.
Utilization Review	Utilization Review (UR) is an important function in the cost recovery process. Because insurance companies require re-cert and continued stay reviews, information gathered by UR staff is critical to both bill creation and collections. UR staff spend little or no time in appeals process at most VA medical centers.	Typically, high performing VHA revenue cycle operations have intimate involvement from a UR nurse. The UR functions can dramatically improve several areas of the revenue cycle from pre-certification through the appeal of a denied claim. A properly trained UR Nurse has the clinical experience to support the processes such as patient access, medical documentation, coding, and review of payment denials.
Encounter Forms	Encounter forms are not being utilized properly. Many times the diagnosis uses wrong codes or general codes which third-party payers will not accept. This problem causes a major rework for billers.	Develop and mandate use of electronic encounter form and documentation template. VHA provider documentation, in many instances, lacks the required elements that result in either a non-billable service or a lower valued service.
Accounts Receivable Software	Accounts Receivable software package is not regionally linked or compatible with billing system.	Implement accounts receivable management software. Managing third-party accounts receivable is something VHA can perform more efficiently and should focus attention to improving. Accounts receivable management includes denial management, which should improve VHA's ability to understand reasons insurance companies deny payment.
Litigation Help	Many receivables are currently tied up in litigation. A survey of 24 sites identified that an average of $24 million per site has been referred to General Counsel.	Request VA General Counsel approach Department of Justice on third-party payers. As of May 2001, VHA has over $245 million in third-party accounts receivables referred to General and/or Regional Counsels.

Question 5: How much has the VA spent to enhance its Office of Compliance, and how was this funding spent?

Answer: The Office of Compliance and Business Integrity (CBI) at VA Central Office spent $841,318 in FY 2001. This amount covered salaries for 10 full time equivalent (FTE) staff, contracts for the National CBI Helpline and Compliance Inquiry Reporting and Tracking System (CIRTS), and equipment and supplies. Deployment of the contracted systems did not occur during FY 2001 due to delays in the approval of a New System of Records. Therefore, $1,247,682 was placed in the One-VA Fund to offset deployment and operational costs anticipated during FY 2002 and beyond.

Question 6: Although Medical Care Collection Fund (MCCF) collections have been increasing in Fiscal Year (FY) 2001, the Veterans Health Administration (VHA) did not achieve its collection goals for FYs 1997 to 2000. Please explain why this is the case.

Answer: There are very complex reasons why VHA did not meet the projected collection goals for FY 1997 through 2000. A 1998 audit of the MCCR Program conducted by VA's OIG cited the following reasons:

> "Analysis of questionnaire responses from the 22 VISN Directors, regarding their role and responsibility in relation to the MCCR Program indicated significant differences in the oversight of the MCCR Program among VISNs. Response from the VISN Directors, which achieved their collection goals, indicated a more active oversight of MCCR activities. Those VISNs which did not achieve goals indicated their oversight generally was limited to review of MCCR billing and collection reports submitted by the facilities."
>
> "VHA had not established performance standards for facility staff conducting patient registration, billing, collection and utilization review to monitor performance results. Our analysis of questionnaires received from 149 VHA facilities indicate that management tools developed by the MCCR Program Office (Preregistration, Autobiller, and Diagnostic Measures) can enhance identification of insurance policies and ensure that billing and collection follow-up is accomplished. However, use of the management tools was not mandated and as a result we found that many facilities had not used these management tools."
>
> "During our review we did not find any examples of best practices of how to promote the MCCR Program. Facility staff and patients were generally not provided information on how MCCR recoveries benefit each facility's ability to provide medical services to patients or the detrimental consequences if MCCR funds were not available."

The issues cited by the Office of Inspector General were basically process-related. However, other environmental and cultural issues have also been a challenge for the Revenue Program. These factors include:

1) A significant shift from an inpatient-focused system of care to one that is outpatient-based.
2) Veterans have been reluctant to disclose if they are covered by private health insurance. Additionally, we have been unable to effectively identify veterans covered under health care plans from commercial sources.
3) High demographic concentration of Managed Care or Health Maintenance Organizations (HMO) in highly populated areas of the country.
4) The implementation of reasonable charges required facilities to retool the process of billing an insurance company for the service provided. This required facilities to implement a new process as we were now generating itemized bills to an insurance company for the service provided rather than a per diem bill.

Question 7: What has the VA done to increase collections? Which VISNs or individual facilities are doing well? Why? What are the more successful managers doing that others are not?

Answer: VA has undertaken numerous efforts to improve its collections. Some areas that have been successful are:

a) reduction of outstanding receivables,
b) creation of pseudo Medicare remittance advice (MRA) for submission to secondary payers,
c) conversion to Reasonable Charges for care provided,
d) exploring automated processes to improve accuracy and integrity of claims through claims analyzer and encoders,
e) improving coding and documentation,
f) developing a First Party Lockbox,
g) participation in the Treasury Offset Program, and
h) development of the Electronic Data Interchange (EDI).

There have been many successful programs within VISNs, but VISN 8 has consistently collected the most money. Part of its success traces back to mandatory use of Computerized Patient Records System (CPRS) and subcontracting of parts of the revenue process where skilled staff members were not available or were in the process of being trained, i.e. accounts receivable follow-up and coding.

There are common denominators that all of our successful VISN's and medical centers share. They include:

a) engagement in understanding the revenue program,
b) a shared vision between the program and the entire organization,
c) commitment of leadership to the program,
d) the expectation that managers and staff will succeed,
e) a focus on training and education,

f) a commitment to reducing outstanding receivables, and
g) use of contractual help when needed.

Question 8: How do you plan to hold responsible managers at VA Central Office, the VISNs, and the local medical facilities accountable for MCCF collection results?

Answer: We have proposed that all responsible managers, to include those in VA Central Office, the VISNs, and the local medical facilities, have their performance standards amended to include measures that are revenue-related. The new standards would include reduction in the outstanding receivables and reduction in the billing lag time. These performance standards are currently under review, and we expect them to be implemented within the next few months.

As previously indicated, the Office of Compliance and Business Integrity has introduced Compliance and Business Integrity Performance Indicators and a phased implementation plan for performance monitoring. This effort will cross all VHA levels (VA Central Office, VISNs, and VAMCs) and will encompass structure, process, and outcome indicators of effectiveness. Phase I, Design of Indicators for Monitoring, was completed December 15, 2001. Phase II, System-wide Rollout of the Performance Monitoring Plan, is projected for completion by April 30, 2002, with baseline data collection on the monitoring plan slated for completion by September 30, 2002. Phase IV, Proposed CBI Network Performance Measures, is scheduled for approval by December 31, 2002. The overarching goal is to ensure compliance program effectiveness, which includes collecting and keeping all revenue to which we are entitled.

Question 9: Please furnish a list of all consultant, OIG, and GAO reports or studies VHA has received regarding the MCCF program since 1996. Please summarize the recommendations made and explain how VHA implemented each recommendation. If recommendations were not implemented, please advise why they were not.

Answer: Please see attachment "Revenue Office Studies and Reports."

Question 10. What is VHA doing to improve collections in the following areas?

A) Patient registration to include means testing and health insurance identification.

Answer: The VHA Chief Finance Officer's Revenue Office is currently participating in two insurance identification pilot projects. Because insurance coverage tends to vary by region, no one vendor can provide an identification service that covers all states. Therefore, we are piloting different projects both to determine the best solution and to reach the majority of carriers.

(1) WebMD's Veriquest product verifies insurance coverage. WebMD is partnering with VHA to add a search of insurance databases using veteran's demographic data to

identify insurance when the veteran has not provided insurance data. In this pilot, Veriquest returns policy information as well as confirmation that coverage is active. Two VA medical centers are currently testing the functionality. We plan to add enhancements to VistA utilizing the data returned from Veriquest as soon as development resources are available to write the enhancement. The resources are not currently available to write the interface. VHA software development resources are involved in other high-priority assignments, and no projected date of delivery is available at this time.

(2) United Integrated System (UIS) is collecting demographic data from veterans who have visited one of the VA facilities in VISN 1 and who have failed to report their insurance data. UIS is querying several insurance databases covering the Massachusetts area. Initial results have been returned from UIS with minimal matches. On the basis of these initial results, the UIS solution may not be a viable solution. UIS uses WebMD as the gateway to insurance carriers.

As part of the Secretary's Revenue Improvement Plan, a file is being proposed that would capture insurance information for employers. This file would allow VA to determine insurance coverage of employed veterans when they provide employer information but fail to provide insurance information. This file will be designed and implemented in VistA once development resources become available.

B) Documentation of treatment in the patient's medical record and accurate coding of the diagnosis and/or medical procedures provided using industry standard codes, such as International Classification of Disease ((ICD-9-CM) and Current Procedural Terminology (CPT-4)

Answer: VHA adopted the industry standard code sets for use in recording clinical interventions. These code sets include ICD-9-CM, CPT-4 and Health Care Financing Administration's Common Procedure Coding System (HCPCS level II) National codes. VHA limits the database selection to the approved code sets and maintains current versions of each within our computer systems. In addition VHA adopted the national published guidelines that accompany these standard code sets.

VA provides national training and information on coding and documentation through several mediums. In July of 1999, VA began monthly satellite network training on coding and documentation. These monthly programs have addressed a variety of related topics including medical legal documentation, evaluation and management coding, and documentation. This information has been reinforced at the local level with training within the medical centers and clinics. The local training initiatives vary greatly by VISN.

Each facility was required to hire a compliance officer, and the individuals in these positions in conjunction with the Health Information Management (HIM) staff serve as local subject matter experts. VHA coding training is ongoing and includes the formation of a Coding Council that responds to questions submitted by VA medical centers and publishes a coding newsletter. VA has also produced a coding handbook that

augments the national published coding guidelines. The first publication of the Coding Handbook was in December 1999. Revisions are published annually.

All VA facilities are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Documentation practices are reviewed in conjunction with the JCAHO criteria. The JCAHO requires periodic review of clinical documentation to ensure compliance with required published Joint Commission standards and local medical center by-laws. The reviews of medical record documentation are performed throughout the year and results are reported quarterly to the responsible clinical committee. The reviews are part of the performance improvement and information management standards within the JCAHO.

VA future initiatives include formalizing a clinical training program on documentation and coding for national distribution. We also plan to continue the monthly coding and documentation satellite series; will publish revised medical record guidance. We are developing discipline-specific electronic documentation templates the first of which will be ready for distribution in the second quarter of FY 2002.

Medical record audits are performed at the individual medical centers, and many sites have enlisted external reviewers to perform audits, provide feedback and develop subsequent training from this feedback. Nationally, we also use these audit results in formulating training programs.

C) Timely issuance of bills and aggressive follow-up on delinquent accounts receivable.

Answer: Several initiatives are underway that will contribute to the timely issuance of bills and accounts receivable follow-up. In addition to efforts to improve coding, contracts for medical coding services will help VHA validate medical codes at different facilities.

To achieve compliance with the provisions of Health Insurance Portability and Accountability Act of 1996 (HIPAA), VHA has been working on an Electronic Data Interchange (EDI). EDI will enable facilities to submit electronic claims to insurance companies. We anticipate that this software will be released in March 2002, and will provide substantial improvements to VA's billing and accounts receivable operations.

VHA currently contracts with a private sector firm for third-party accounts receivable follow-up. Additionally, we are piloting with a private sector firm to develop enhancements to the revenue process that target more aggressive follow-up actions. These pilots include contacting an insurance company after a second notification is generated to determine if payment has been sent or if the insurance company is waiting for additional information. Additionally, we are piloting with another company to develop software to identify third-party accounts that need follow-up action. This software will stratify the receivables by dollar value and age to provide a facility with a list of problem cases needing attention.

We are also in the process of assessing the feasibility of contracting with a private sector firm for all or portions of the accounts receivable function. Other possibilities under consideration include consolidation of accounts receivable follow-up within and among VISNs.

Question 11: What is the total number of uncollected bills and total dollar amount of VHA's backlogged unbilled medical care? Why does this backlog exist and what actions are being taken to clear the backlog?

Answer: The current value of all outstanding claims is $710.8 million. This figure does not reflect the amount that we expect to collect. Claims are reduced based on the benefit provisions of the insurance policy, including considerations such as supplements to Medicare, limitations, exclusions, insurance deductibles, and co-payment requirements. For example, we bill Medigap insurers the full charges for any procedures provided by VA but receive reimbursement only for services covered by the Medigap policy. We do not bill the patient for the remaining balance of the claim, as is done in the private sector.

We estimate that the unbilled medical care amount is $1.052 billion. This figure represents the national accumulation of all potentially billable episodes of care for the last two years. This figure is derived from a report that was introduced to the system in July 2001. Because this new report collects different information than the report relied on previously, facilities are now able to identify and clean up non-billable procedures that were previously counted as billable. We estimate that the clean up report will be completed by the end of January 2002.

Question 12: During FY 2000, VHA collected $573 million. What were VHA's MCCF program costs during FY 2000?

Answer: VHA's MCCF program costs for FY 2000 were approximately $114 million. This total includes the costs for the Central Office Program Office, Special Projects, the Office of Finance and IRM, VA's General Counsel, Information Systems Centers, National Field Director's, Learning Resources/Continuing Education Centers, Field Stations, the Austin Finance Center, and operating equipment.

Question 13: What performance standards have been established for facility staff who conduct the following tasks? a) Patient registration; b) Medical record documentation and coding; c) Billing; and d) Collection and follow-up of delinquent accounts.

Answer: Patient registration, billing and collection and follow-up of delinquent accounts were established through the Revenue Office and can be measured in Central Office or at the VISN/medical center level. Medical record documentation and coding standards have been established but are measured only at the medical center and VISN level.

Patient registration standards are measured through internal metric reports from the Percentage of Completed Registrations, Veterans with Unverified Eligibility, No Employer Listed, and Patient Insurance Statistics Reports.

The Office of Compliance and Business Integrity has included completeness, currency, and accuracy of patient registration data as one of their CBI program indicators. A registration record will be considered complete if it contains all the data elements as determined by Revenue Office Policy. A registration record is not current unless all information is documented as having been verified within the previous 6 months. A registration record is not accurate unless each of the required demographic, financial, insurance eligibility, and other required elements are supported by documentation of its substantive accuracy.

Billing standards are measured through internal metric reports from the Revenue Office Diagnostic Measures. The specific report is the Bill-Lag Time, which measures the time it takes to create a bill to an insurance company from Date of Check Out or Date Patient Treatment File (PTF) to Date Claim Activated.

Collection and follow-up of delinquent accounts again are measured through internal metric reports from the Revenue Office Diagnostic Measures. The specific reports are the Bill-Lag Time report, which will measure from the Date Claim Activated to First Payment Date, and the Third Part Follow-up report, which indicates the number of days a claim has been outstanding.

Currently, standards for documentation and coding are monitored on a local basis. The guidelines followed are those published by VHA and provided by JCAHO. Per the Revenue Improvement Plan, coding standards are being developed for national distribution in the second quarter of FY 2002.

Question 14: Has the VA tried to obtain patient health insurance coverage information from other sources, such as the Department of Health and Human Services?

Answer: VA has been in contact with the Department of Health and Human Services (HHS), specifically the Centers for Medicare and Medicaid (CMS) Office of Strategic planning. CMS staff has informed VA of a database they maintain that contains third-party health insurance information. This information could be beneficial to VA in identifying additional insurance coverage for a larger percentage of veterans. Because of concerns with Privacy Act restrictions, the CMS General Counsel has been asked for an opinion on whether third-party health insurance information can be shared with any other entity, including another Government agency. VA is currently awaiting a decision by the CMS General Counsel before proceeding with this project.

As stated previously, VA has a number of pilot projects with private vendors to gather insurance information.

Question 15: Please assess the capacity of VHA's current IT systems to support MCCF collections and program oversight. What improvements are needed?

Answer: Currently VHA's billing and collections are managed through two decentralized Veterans Information Systems & Technology Architecture (VistA) applications referred to as Integrated Billing and Accounts Receivable. Both applications evolved from other VistA applications over the past 10 years as the revenue needs of VHA have increased. Unfortunately, as these applications were developed over time, software was written to meet the immediate needs rather than to serve as more robust applications that could meet future needs. In some areas such as first-party billing, VistA is extremely robust, and there is little opportunity to provide enhancements or replacement applications that could provide significant increases in collections. On the other hand, in the third-party billing module there are several areas where the software fails to meet the current requirements of VHA.

Integrated Billing does not have a true patient account that is able to capture all potentially billable events for a patient's episode of care. Thus, we are unable to identify electronically specific treatment services, as they are entered into VistA, that are billable to third-party insurance carriers, and this deficiency has manifested itself with the advent of Reasonable Charges. This is one of the reasons why it takes so long for VHA to prepare an accurate claim. The receivables management system works adequately but lags well behind commercial software offerings with regard to providing the best tools to manage and follow up on delinquent receivables.

Systems improvements are needed regarding claim preparation, and to a lesser extent, the receivables management system. We also need to implement an enhanced patient account to capture all services that are potentially billable. This work has begun as the Billing Awareness project. These new systems, in conjunction with the implementation of commercially available encoder and claims analyzer systems, will position VHA to create healthcare claims much more quickly. Decreasing the amount of time to create and submit to payers an accurate and correct healthcare claim will increase the probability that the claim will be paid more quickly.

Several other improvements would also support increased and faster billings and collections. A substantial effort is being placed behind the implementation of electronic data interchange (EDI) in support of Health Insurance Portability and Accountability Act (HIPAA) requirements. Electronic transmission of claims and payments should decrease the billing cycle time from the billable episode of care until final payment is received. Enhancements in support of insurance verification should help VHA better identify those veterans with insurance and, therefore, increase revenues. Both of these enhancements could be provided through enhancements within VistA or as part of a commercial replacement. A centralized database for all billing and collection information is needed to provide information

at the medical center, VISN, and national level. This would require a replacement system either procured commercially or built within house.

Although VistA's current billing and collections applications meet many of VHA's needs, there are still a number of deficiencies that make them less than ideal. Current work in support of Billing Awareness, EDI and Reasonable Charges will go a long way toward making the current systems more robust. Unfortunately, without a complete re-write of the current systems or procurement of a commercial system, VistA will never be able to provide a complete system that will meet all of VHA's needs. Either approach (upgrade existing software or replace with commercial applications) will take 2-3 years to complete once actual work begins. Funding, especially of a commercial replacement that could approach $100 million, will also be a significant barrier.

Question 16: What is the VA doing to train clinical staff in medical record documentation?

Answer: VA provides national training and information through several media. In July of 1999, VA began monthly satellite network training on coding and documentation. These monthly programs have addressed a variety of related topics including medical legal documentation, evaluation and management coding, and documentation. This information has been reinforced at the local level with training within the medical centers and clinics.

All VA facilities are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and documentation practices are reviewed in conjunction with the JCAHO criteria. VA future initiatives include formalizing a clinical training program for distribution nationally through the collaboration of the Employee Education Service (EES) and the Health Information Management (HIM) Office and continuation of the coding and documentation satellite series.

Members of the VHA HIM Coding Council work with specialty program offices (i.e. behavioral health) in researching and providing guidance on specialty specific issues (i.e. mental health fact sheet). This information is then available nationally on VA Intranet web sites. The HIM Coding Council also publishes a monthly coding and documentation newsletter that is distributed to all VHA medical centers.

Question 17: What is the VA doing to ensure that clinical staff document treatment in patient medical records accurately and timely?

Answer: As noted above, VA has several training initiatives in place and is working on future initiatives. Medical record audits are performed at the individual medical centers and many sites have enlisted external reviewers to perform audits, provide feedback, and develop subsequent training from this feedback. Nationally, we also use these audit results in formulating training programs. The

JCAHO requires periodic review of clinical documentation to ensure compliance with required published JCAHO standards and local medical center by-laws. The reviews of medical record documentation are performed throughout the year and results are reported quarterly to the responsible clinical committee. The reviews are part of the performance improvement and information management standards within the JCAHO.

The VA HIM Office is developing, in conjunction with EES, an audit tools program for VA managers to use to monitor documentation at facilities and to use to provide feedback to clinicians. This group is also discussing additional training for managers to assure understanding of documentation issues and requirements.

Question 18: Please assess the adequacy of staff resources assigned to MCCF program duties. If you believe additional staff are needed, have you determined how many and what skills are needed? What is the basis for your determination?

Answer: VISN resources are adequate as exemplified by FY 2001 collections. The FY 2001 collections of $771 million exceeded the FY 2001 goal of $675 million by $96 million (14 percent). The FY 2000 collections of $573 million exceeded our goal by $198 million (35 percent). VA is approaching improvements to collections by several avenues. A national pilot is under way to contract with the private sector to determine if contracting certain aspects of MCCF activities will improve collections. Best practices are shared among VISNs, and many VISNs have already begun consolidation of MCCF activities.

Question 19: What MCCF functions are private contractors performing? What specific tasks do the contractors perform that cannot be performed by VHA? What benefit does VHA realize by using private contractors? Should additional contracting be used?

Answer: Private contractors are currently performing a variety of services to support the VHA billing and collection process. The services vary by medical center and VISN. Some of the services currently being contracted out within the VHA include follow-up and collections for accounts receivable, diagnostic and procedure coding of inpatient and outpatient medical services, insurance identification, insurance verification, electronic claims filing, coding and billing data validation and audits, and educational activities in support of the revenue process, such as physician training for coding and documentation (including Medicare guidelines), coding training for administrative personnel to achieve credentialed coding status, and completion of claims to insurance carriers.

There are no specific tasks performed by contractors that cannot be performed by the VHA. VHA is currently pilot testing different approaches to insurance identification with a number of private concerns.

VHA often uses contractors to perform work that can be performed more efficiently in a production atmosphere by personnel trained to perform specific functions such as

collections. We also contract in some circumstances to obtain a higher level of expertise. Using private contractors to provide training and education to both professional and administrative staff brings the perspective and importance of factors faced in the private sector regarding claims generation and payment. The use of contractors also provides VHA a workforce that is capable of completing work immediately. Hiring new VHA employees, on the other hand, can be time consuming, and there are times when additional assistance is needed for a short period of time; bringing in trained contract staff can be done quickly to meet a critical need.

The use of contractors to collect revenue should be a viable option for every VISN and for every medical center. VHA is currently studying how best to configure such contracts.

The lesson learned to date is that the major inhibiting factor to using contractors for billing and collection is development of a secure and sophisticated information technology interface between VHA's VistA System and the contractor's own software systems. This interface is critical because without it the VHA cannot take advantage of the contractor's internal capability and efficiency.

Question 20: Please assess the feasibility of consolidating specific functions such as patient registration, billing, or collection at the VISN or national level?

Answer: Consolidation of revenue collection functions at the VISN level is certainly feasible. A number of VISNs have already consolidated select revenue activities and found the arrangement effective. For example, VISN 9 has consolidated pre-registration, insurance verification, billing, collection, and customer service at Murfreesboro, Tennessee. VISN 2, in upstate New York, has consolidated collections at the Buffalo VAMC and billing at the Albany VAMC.

We are currently testing and evaluating the impact of consolidation at two test VISNs. VISN 12 will operate a consolidated customer service, collections and billing unit at Madison, Wisconsin. VISN 6 is establishing a Consolidated Revenue Unit (CRU) at Asheville, North Carolina. This unit will have responsibility for performing pre-registration, insurance verification, billing, collections, and customer service for the entire VISN. The results of these tests will indicate the effect of consolidation on the operation and employees and the impact on net revenue. Initial findings will be presented in an interim report in March 2002, with a final evaluation report in September 2002.

Consolidation and transfer of functions to the national level is possible but has not been thoroughly evaluated. Regardless where billing and collection are performed and regardless whether these activities are performed in-house or by a contractor, the most critical elements of revenue collection remain the responsibility of the medical center. The provision of health care and the associated coding and validation are the medical center's responsibility. The medical center and the VISN are responsible to ensure that these activities are accomplished timely and accurately.

Question 21: Please advise us of the status of VA's litigation with USAA and the Hartford Insurance companies involving $64 million in unpaid claims. Those insurers claimed they were unable to determine how to reimburse VA without a Medicare Explanation of Benefits statement.

Answer: The amounts owed to VA by USAA and The Hartford Insurance companies are in controversy and the subject of ongoing negotiation between the parties to the litigation. In this regard, however, it should be noted that such amounts represent only a portion of VA's gross billing. This is because VA, like private sector providers, bills health plans for the full charges of the care provided. Yet, the coverage at issue is intended only to supplement the Federal Medicare program and, thus, the supplemental insurers' liability is strictly secondary to that program.

The United States does not agree that USAA's and The Hartford's responsibility for reimbursing VA is predicated on their being furnished a Medicare Explanation of Benefits statement. VA, however, under agreement with the Centers for Medicaid and Medicare Services, is in the process of developing an equivalent Medicare Remittance Advice (MRA) in an effort to expedite the adjudication and payment of its claims from supplemental health plans. In part on such basis, the parties are actively engaged in discussions toward effecting payment of VA's claims and settlement of this litigation.

Question 22: How many other cases are in litigation that involve over $1 million in unpaid claims? What is the status of each case?

Answer: We are aware of no such pending litigation.

Question 23a: How much has been collected through the efforts of the VA General Counsel?

Answer: FY 2001 -- $15,866,717.58 (on claims exclusively asserted by OGC)

Question 23b: How many General Counsel Full Time Employee Equivalents (FTEE) are assigned to the MCCF Program?

Answer: 63.03, which accounts for $3.8 million

Question 23c: Please assess the current role of the General Counsel in assisting VHA in the collection of disputed or delinquent debts.

Answer: The Office of General Counsel (OGC), which, in addition to Central Office, includes 23 Regional Counsel offices nationwide, has a very limited role with regard to first-party delinquent debt since the vast majority of such debt is referred to Treasury for offset or cross-servicing in accordance with the Debt Collection Improvement Act. Thus, the OGC's role essentially involves collection of referred third-party debt for VA

medical care under 38 U.S.C. § 1729 and recovery from tortfeasors under the Federal Medical Care Recovery Act (MCRA).

The OGC has exclusive collection responsibility in MCRA, workers' compensation, and no-fault automobile insurance cases. This is appropriate since these cases typically involve dealing with other attorneys and traditional legal advocacy and practice before administrative, judicial, and quasi-judicial bodies. Although time-consuming, such cases, particularly MCRA cases, have often resulted in substantial recovery amounts. We hasten to point out, however, that the zeal to collect in these cases does not dispose us to ignore the veteran's circumstances and to consider compromise or waiver of the debt when the amount of the veteran's recovery, nature of permanent disability, and financial outlook suggest that as the proper course of action.

As to regular reimbursable insurance cases, VHA is instructed to refer to OGC those cases where the dispute/denial of VA's claim implicates legal issues. Thus, for example, the OGC has effectively handled denials of VA medical care claims by insurers who rely on policies and practices that arbitrarily and invidiously discriminate against the Government. These include cases where policy provisions discriminate in practice against VA because they pay only when and to the extent the member incurs personal liability for medical care costs. Unlike the situation in the private sector, of course, veterans do not have such exposure for the costs of VA care.

The OGC has assisted the Justice Department in successfully litigating VA's right to recover from Medicare supplemental insurers and, as noted above, currently is in litigation with USAA and The Hartford over the procedure for billing such insurers. Unfortunately, we believe the overwhelming majority of the claims referred to OGC are either directly or indirectly related to the latter and, thus, will not be resolved until the litigation is concluded.

The OGC has been particularly successful at resolving other disputed debt referrals and issues, both legal and non-legal, largely by requiring full documentation of facts and making personal contact to discuss relevant issues with counsel for the health care plans involved. Frequently, disputes result from inadequate communication and misunderstandings between the parties. VA's implementation of reasonable charges has been of significant benefit in this regard since, unlike the confusion often occasioned by its previous per diem billing, VA's "new" bills more closely resemble those of the private sector. Likewise, the increased use of provider agreements, which the OGC reviews and helps negotiate, has significantly improved the business relationship between VA and health care insurers, and facilitated collection of medical care debts.

Finally, we believe OGC's advice and counsel to VHA, VISN, and VA medical center staff regarding various business issues; participation on Revenue Office and Compliance and Business Integrity Office committees; and training activities all have contributed to assisting VHA in collecting disputed or delinquent debt.

Question 23d: What additional assistance will be needed?

Answer: We believe concluding the USAA litigation and implementing the MRA will dramatically improve insurance reimbursement processing. Meanwhile, OGC will review claims referral guidelines and processes to determine whether they need improvement or updating. Further, we see a need to work toward better management of referred claims, to include more effective screening, closing of claims lacking legal merit, and timely collection action on others. Finally, we believe OGC can assist by providing additional training to medical center employees on the nature and identification of tortfeasor and workers compensation cases, for example, so that patients who present with injuries are properly screened and timely referred to OGC.

Question 24: Is there any legislation that you think would assist VHA in increasing MCCF collections?

Answer: VA is preparing several legislative proposals that will be presented once the necessary Executive Branch coordination is completed.

Attachment to VHA Response to Buyer Question 9: Revenue Office Studies and Reports

Date: August 1997
Study/Report: Survey of Commercial-Off-The-Shelf Products for a Universal Billing System
Contractor: Birch & Davis Associates, Inc.

Summary: This report was requested by VHA to provide an analysis of commercial products used for health care billing and collection efforts in the private sector. This information was used in support of recommending a universal billing and collection system for all VHA financial transactions.

Date: August 1997
Study/Report: Universal Billing System for Veterans Health Administration
Contractor: Birch & Davis Associates, Inc.

Recommendation: That VHA should pursue a long-term automated solution that would identify and capture all current and future revenue streams. In addition, this report recommended that VHA buy a commercial solution with a relational database and adapt the solution to meet VHA and VistA requirements. VHA's CIO would take lead responsibility on this project.

Status: The Universal Billing solution became wrapped up in a multi-purpose Managed Care initiative that included all administrative systems enhancements to VistA. Because the initiative included so many different systems enhancements the cost of the initiative became prohibitive. Recently the Revenue Office charged a workgroup with the task of studying the universal billing solution as a separate initiative again and is currently exploring commercial products. Based on Workgroup recommendations, VHA may request funding approval from the Capital Investment Board.

Date: October 1997
Study/Report: Universal Billing System Functional Requirements Document
Contractor: Birch & Davis Associates, Inc.

Summary: This report was requested by VHA to provide systems requirement specification in support of a universal billing and collection system for all VHA financial transactions. The report supports a Universal Billing system for VHA and was used by the initial Universal Billing workgroup.

Date: October 1997
Study/Report: VA Medical Care, Increasing Recoveries From Private Health Insurers Will Prove Difficult
Contractor: GAO Report, GAO/HEHS-98-4

Recommendation #1: Establish procedures to work with state insurance commissions to ensure that exclusionary clauses inconsistent with VA's recovery authority are removed from private health insurance policies.

Action: In the course of considering the best approach to implement this recommendation, VHA and the Office of General Counsel determined as a first step to develop a regulation that would clearly express VA's statutory recovery authority, notwithstanding any discriminatory policy provisions to the contrary. GC has responsibility for this recommendation. We are in the process of initiating such rulemaking and believe this action conceivably could have at least equal effect to the recommendation and could obviate the need for further corrective action.

Status: Pending.

Recommendation #2: Work with the Director, OPM, to determine the extent to which FEHBP plans were overpaid for VA care provided to Medicare eligible policyholders and the extent to which any such overpayments should be refunded.

Action: Representatives from the MCCR Program Office met with OPM officials and were informed that FEHBP plans would not seek reimbursement for the overpayments.

Status: Completed.

Recommendation #3: Work with the Director, OPM, to develop mutually beneficial changes in how FEHBP plans will reimburse VA for services provided to Medicare eligible veteran policy holders.

Action: Representatives from the MCCR Program Office met with OPM officials and were informed that VA facilities would be reimbursed in the same manner from FEHBP plans as the private sector is reimbursed when the beneficiary receiving medical care is a Medicare beneficiary.

Status: Completed.

Recommendation #4: Work with the Director, OPM, to identify options for including VA facilities as preferred or participating providers under FEHBP plans, including HMOs and preferred provider plans.

Action: Representatives from the MCCR Program Office met with OPM officials and were informed that preferred or participating provider status was determined by the individual carrier. OPM has no control over negotiating this status with the individual carrier or the VA. The MCCR Program Office will continue to encourage medical centers to individually contact health insurance carriers and seek preferred or participating provider status.

Status: Completed.

Recommendation #5: Design physician incentives to encourage appropriate use of hospital care. Such incentives should not, however, be so strong that they would result in denial of needed hospital care.

Action: VHA did not concur with this recommendation because VHA believes that adequate incentives have been established through the Veterans Equitable Resource Allocation (VERA) system and performance measures.

Status: VHA non-concurred with recommendation.

Recommendation #6: In designing the enrollment process for the veterans health care program develop procedures for gathering and updating detailed information on veterans' employment, insurance, and service-connected disabilities.

Action: These questions have been incorporated into the enrollment process and have been incorporated into the revision of the VAF 10-10.

Status: Completed.

Recommendation #6: Assign adequate resources to MCCR activities to protect the government's interest in resolving insurers' requests for refunds of claimed overpayments.

Action: We believe that most of the carve-out claims have now been settled. There is no reason to believe that this will be an ongoing problem and it is our recommendation that this item be considered closed.

Status: Completed.

Recommendation #7: Develop procedures to ensure that authority to retain health insurance recoveries would not detract from services to veterans who lack private health insurance.

Status: Whether a veteran has billable insurance or not is not a stipulation for enrollment.

Date: December 1997
Study/Report: VHA/CFO Data Mart – Requirements Analysis and Benefit/Cost Study
Contractor: Mitretek

Recommendations: Significant changes in VHA, both in the delivery of health care and alternative revenue streams, increase the requirement for current up-to-date system wide information. The responsibilities of the VHA Office of the Chief Financial Officer (VHA/CFO) at headquarters become more complex due to the distribution of authority and responsibility, requiring an improved data analysis capability. This improved data analysis capability, achieved through the VHA/CFO Data Mart Initiative, is intended to provide timely access to computerized strategic information for VHA/CFO Revenue Office and to enable decision makers to more effectively manage the program as dramatic changes in health care reimbursement occur. The information is highly granular, including SSN level details of all MCCF bills and claims issued system wide.

Status: The recommendation received Department level approval for implementation. The project is nearing completion.

Date: February 1998
Study/Report: Immediate Referral of First Party Debt Cost/Benefit Analysis
Contractor: AMA Systems, Inc.

This study was completed to identify and analyze the costs and benefits of the current decentralized Veterans Health Administration (VHA) first party collection system and alternative systems, which could implement a shared service, centralized process between VHA and Veterans Benefits Administration.

Recommendation: AMA recommended that VHA pursue a centralized first party debt collection and management system.

Action: Representatives from VHA met with VBA and the Office of Financial Policy to review the study. It was determined not to pursue a centralized first party debt collection system at this time, because a number of other initiatives were being pursued by VHA to enhance the first party collection process (i.e., First Party Lockbox, Treasury Offset Program).

Status: Complete.

Date: July 1998
Study/Report: Audit of the Medical Care Cost Recovery Program
Contractor: IG Report, 8R1-G01-118

Recommendation #1: Requiring VISN Directors to more actively manage MCCR program activities in their networks to include (a) developing performance measures to improve the timeliness and accuracy of billings and the management of accounts receivable, (b) monitoring the performance results and (c) taking corrective action to improve performance gaps.

Response: VHA established VISN collection goals as the performance indicator. The MCCR Diagnostic Reports have been formatted into templates, which are accessible through the VA Intranet. Networks can access these diagnostic measures and self-monitor items such as billing lag time reports, accounts receivable, and other revenue processes. (Headquarters CFO staff does not routinely monitor these indicators.)

The CNO is fully supportive of these efforts and has recently written letters to all Network Directors whose collections are 90% below the goal attainment level for the first half of the fiscal year. The CNO has indicated that their progress will be closely monitored with data provided from the CFO.

Additionally the Under Secretary for Health (USH) has addressed the Network Directors, in memoranda, face-to-face meetings and through individual telephone contacts. The USH has emphasized the importance of this program. A monthly report is provided to the USH and CNO on the collection performance of each network. This reemphasis has resulted in VISNs working closely with Regional Counsels to improve recoveries on accounts receivable.

Recommendation #2: Mandating the use of management tools (Preregistration, Autobiller, and Diagnostic Measures) at all facilities to better ensure veterans' health insurance carriers are identified, appropriate billing is accomplished in a timely manner, and collection of accounts receivable is pursued effectively.

Response: Concur. Use of these tools was stressed at the network training sessions as indicated in the above response as well as in numerous conference calls, previous training sessions, and newsletters.

Software installation is mandated upon release; however, the use of the software is not mandated. The CFO's Re-engineering Committee has prepared a directive mandating the use of the pre-registration software and processes at all medical centers. This directive will be undergoing concurrence through VHA Headquarters within the next several weeks. This directive will include instructions for standardizing inconsistency checks that must be placed on various fields within the pre-registration software. A report will be submitted to the CFO Revenue Office, by each medical center, for baseline analysis of incomplete registration data. The report will then be generated on a quarterly or semi-annual basis to determine the progress being made on improving our databases and customer service. The Re-engineering Committee has been asked to develop a similar directive with respect to cleaning up the Integrated Billing (IB) Software insurance file. This directive will provide a mandate for turning on all autobiller functions within the IB software upon completion of the clean-up effort. The Revenue Office will be following up with performance measures to ensure that the software is being used.

The MCCR Diagnostic Reports have been formatted into templates, which are accessible through the VA Intranet. Networks can access these diagnostic measures and self-monitor items such as billing lag time reports, accounts receivable, and other revenue processes. The Networks have supported these Diagnostic Measures and we have every assurance that their support will continue.

Recommendation #3: Establishing performance standards for staff involved in all phases of MCCR activities to include patient registration, billing, collection, and utilization review and requiring VHA managers to monitor performance results and take action to improve performance gaps and recognize high achievers.

Response: Concur. VHA has established VISN collection goals as the performance indicator.

Recommendation #4: Better promoting the importance of the MCCR program by ensuring VHA facility staff, veterans, and Veteran Service Organizations have access to information demonstrating (a) how MCCR recoveries benefited each facility's ability to provide medical services to patients and (b) the detrimental effect on operations if MCCR funds were not available to supplement facility budgets.

Response: Concur. The USH and VHA CFO held a special Veterans' Service Officer meeting on May 7, 1998 to discuss the Revenue Program. We have held meetings with the VSO's to keep them informed of the Revenue Program and the changes that have affected veterans since that time.

The CFO Revenue Office has developed three brochures covering the issues of third party billing and veterans' copayments. These brochures are *The Ins & Outs of Veterans Copayments & Health Insurance at the VA*; *The Medication Copayment Policy*; and, *Medical Care Recovery Program: A Resource for America's Veterans*. Numerous copies of all three are distributed to every VA medical center on a quarterly basis and are available through the Revenue Office. The Revenue Office has also prepared a tabletop display for field use that highlights the new benefits, services and policies concerning VA's medical care collection activities. These materials highlight the fact that collections now stay in the local area. Additionally, the Revenue Office is planning presentations to Veterans Service Organizations. A set of posters calling attention to the need for insurance disclosure and how veterans and the VA benefit from insurance disclosure is presently being developed by the VHA CFO and the Chief Education Officer for field distribution.

Date: April 1998
Study/Report: VA MCCR National Study, Cost Assessment and Best Practices
Contractor: Coopers and Lybrand

The VISNs, central office and medical centers should all have clear roles in the CPR initiative. VA should assign the following roles and responsibilities for follow-up action.

VISN Recommendations:

1. Take more active leadership roles in revenue cycle operations
2. Hold hospital directors fully accountable, and incentivize them, for program compliance and revenue results
3. Consolidate, as appropriate, revenue cycle front-end operations
4. Adopt central business office models of organization
5. Charter and appoint VISN Revenue Cycle Teams
6. Train Revenue Cycle Teams
7. Conduct VISN-wide CPR planning workshops
8. Deploy Revenue Cycle Teams to medical centers to focus on:
Realizing quick hit opportunities that will accelerate FY 98 cash flow
Implementing process compliance and long-term improvements toward achieving 30/20/10 goals.
9. Communicate activities to all stakeholders, including veterans, VA staff, third party payers, VSOs and unions.

Central Office Recommendations:

1. Develop financial/revenue performance scorecard for VISN accountability
2. Sponsor training for VISN Revenue Cycle Teams
3. Support VISN CPR roll-out planning
4. Provide technical expertise to VISN Revenue Cycle Teams, as required
5. Continue technical assistance and training support for all revenue cycle operations
6. Continue development of common tools and technology
7. Press for full implementation of the MEO by the Year 2000

Medical Center Recommendations:

1. Hold all executive leadership and department heads accountable for revenue performance
2. Assure program compliance by establishing internal control systems in accordance with Circular A-123
3. Use the Diagnostic Measurement System to establish accountability
4. Begin implementation of the central business office model
5. Send top management team (financial, clinical, administrative) to VISN-wide CPR planning workshops
6. Participate on VISN Revenue Cycle Teams
7. Implement corrective actions

MILESTONES:

1. Continuous	Comply with established MCCR program requirements and standards
2. Immediately	Announce an aggressive revenue streams follow-up initiative (completed)
3. Winter 1998	Create VISN Revenue Cycle Teams (in process)

4. Early Spring 1998	Train VISN Revenue Cycle Teams, each plan VISN-wide initiatives (in process)
5. Spring-Fall 1998	Deploy Teams to medical centers
6. Summer 1998	Report progress to Undersecretary for Health
7. Summer-Fall 1998	Realize quick-hit revenue opportunities
8. Fall/Winter 1998	Redesign VISN and medical center revenue cycle operations
9. Winter 1999	Implement Universal Billing System, Reasonable Charges, other national revenue initiatives
10. Continuous	Negotiate preferred provider, sharing, other revenue generating contracts
11. Spring 1999	Internally franchise and/or contract appropriate revenue processes
12. Year 2000	Implement MEO
13. Year 2002	Achieve 30/20/10

Date: January 1999
Study/Report: Billing and Coding Audit Report
Contractor: Rainbow Technology/First Consulting Group

Recommendations:

Operational Efficiency - Re-examine, as an initial strategy, VHA's policies, rules and regulations regarding documentation requirements for individual reports and entries in the medical record.

Re-establish or, in some cases, establish baseline expectations regarding content and format for both paper and electronic information.

Develop a review process to analyze claim denials to understand the most frequent reasons they occur.

Research the possibility of relocating professional outpatient coders to the registration or clinic area to assist in obtaining information and to perform real-time coding.

Develop an educational program for providers, realizing constraints on time and level of interest and the need to structure the content of the educational program so the provider participates and views it as useful.

Implement a "no excuses" policy that information must be complete before testing and procedures are performed.

Implement an encoder or encoding system, which can enhance compliance with coding guidelines and assure optimum reimbursement.

Develop and implement a continuous quality improvement program for coding. Propose a program to install automated encoders throughout the VHA system.

Undertake a VHA-wide encounter form redesign initiative to facilitate the code capture and billing processes while maintaining the ability to appropriately capture workload.

Seek input from HIMS professionals to ensure accuracy of codes and appropriateness of diagnosis and procedure listings as well as to foster provider confidence in the forms.

Implement consistent encounter form development and maintenance processes across the VHA.

Determine the method for development of new encounter forms and the method and frequency with which encounter forms will be systematically reviewed. Include personnel involved in the process.

Policy - Implement documentation standards utilizing Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards as a guideline.

Evaluate the potential to develop a code of ethics/standards of performance that not only includes coding and billing expectations but also specifies requirements for adequate and appropriate documentation, maintenance of master patient index, transcription ethics, and confidentiality standards.

Software Functionality - Re-design the current process of transferring electronic information from the encounter form to POE to IB to ensure that complete, clear, and accurate documentation is captured on all VHA patient encounters.

Evaluate the IS system and PCE to determine whether there is a technical reason for inconsistencies in data between these two systems.

Review the use of the Autobiller's accuracy in producing claims submitted by coding staff.

Evaluate the limitation of a 5-diagnosis code maximum for the Autobiller.

Educational - Provide educational sessions for providers covering the regulations and requirements for documentation to support medical necessity for outpatient testing and procedures.

Train and educate all VHA clinic staff and ancillary staff who have responsibility for collecting medical information. Make sure they are knowledgeable about the information requirements and completely understand why the information is needed.

Integrity - Develop a committee to define and refine appropriate review criteria to assess documentation, particularly as it relates to coding.

Status: The recommendations from this report indicate that the success of the Revenue Process depends on more than just billers and accounts receivable clerks. Clinicians, coders, information systems specialists, compliance officers, and local management play key roles. This report has been shared with all responsible offices.

Date: January 1999
Study/Report: What Produces High Potential Collections from Third-Party Insurance? A Comparison of VISN's Using the FY 1998 Model for MCCR Third-Party Projections
Contractor: Management Decision and Research Center

Summary: This report was conducted to examine the performance differences between VISN's using the FY 1998 alternative revenue model. There were no formal recommendations, however, by understanding the differences it was helpful to those responsible for enhancing and developing subsequent year revenue models.

Specifically we learned that VISN performance differed greatly in potential collections even when potential collections were expressed per resident veteran or per user of the VHA system. For simple total potential collections, 14 VISNs differed by more than 20% from the median of all VISNs. Four factors were the principal contributors to these differences:
1. Breadth of utilization (users per veteran)
2. Intensity of utilization (discharges, inpatient days or visits per user), especially inpatient days per user.
3. Rate of non-HMO insurance in areas served by the VISN
4. Average bill rate reflected by the mix between inpatient and outpatient services
With only two VISNs as exceptions, differences among VISNs in collection and in the proportion of veterans with some insurance are not very important in generating differences in potential collections.

Date: May 1999
Study/Report: Report on Private Industry Trends and Practices for Outpatient Co-pays
Contractor: PricewaterhouseCoopers

Recommendation: There were no recommendations. This report merely was a compilation of information on how outpatient copayments are handled by private sector health care providers and payers.

Status: At the time outpatient copays were $45.80 and compared unfavorably with the private sector managed care rates of $5 - $10 for in-network providers. The information in this report was used to assist a VHA copay work group in their effort to develop options on copayment policy and rates.

Date: June 1999
Study/Report: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain
Contractor: GAO Report, GAO/HEHS-99-124

Recommendations: To help ensure that VA does not forego some of the amount that insurers usually pay other providers for the same service in the same locality, we recommend that the Secretary of Veterans Affairs establish and implement policy and procedures to (1) monitor reasonable charges and identify those that should be increased to conform with local market prices and (2) verify the appropriateness of insurers' payments when they pay an amount less than VA's reasonable charges.

Actions and Status:

Recommendation #1: VA's reasonable charges were designed to be set at the 80th percentile of charges in the market area of each VA facility. We originally used Metropolitan Statistical Areas (MSAs) for our market areas for inpatient facility charges. In reviewing the reasonable charges project, GAO found some instances in which VA's inpatient facility charges appeared to be lower than the 80th percentile. In reviewing GAO's findings, the reasonable charges contractor determined that significant differences in charge levels sometimes occur in different locations within large metropolitan areas, and that using MSAs as our market areas resulted in charges in some parts of MSAs that were lower than 80th percentile. The solution identified is to change to market areas based on the first three digits of ZIP Codes. This change will result in smaller market areas, and is expected to produce charges that are more sensitive to local variations within the same MSA. The change from MSA-based market areas to three-digit ZIP Code market areas has been incorporated into an update to reasonable charges.

Recommendation #2: Reasonable charges billing is specific to hundreds of Diagnosis Related Groups (DRGs) and thousands of Current Procedural Terminology (CPT) codes. Routine verification at this level of detail regarding the appropriateness of insurers' payments when they pay an amount less than VA's reasonable charges requires databases and procedures that were not in place at the time reasonable charges were implemented in September 1999. Since then, much work has gone into development of a new claims and collections database that will help us in this regard. Meanwhile, VA facilities and VISNs have experienced mixed results in obtaining verification from insurance companies regarding their usual, customary, and reasonable (UCR) payments, and in some cases VA Regional Counsels have been asked to assist. Adding to the complexity is the fact that insurance companies pay providers differently, depending on the presence or absence of preferred provider agreements and other contractual arrangements. So in summary, we are not yet in position to routinely verify the appropriateness of insurers' payments when they pay us less than our charges, but we have made some progress, and our efforts in this area have been substantial and are ongoing.

Date: July 1999
Study/Report: Who Has Insurance? An Evaluation of the Insurance of the Insurance Indicator in Outpatient Visit Data for Forecasting Alternative Revenues
Contractor: Management Decision and Research Center

Recommendation #1: Audit the OPC indicator and the insurance information that lies behind it.

Status: Medical centers are responsible for ensuring data integrity.

Recommendation #2: Correct conceptual flaws in the OPC insurance indicator. The single data item should be expanded to at least three items to handle the needs of MCCR whether privately insured, whether eligible for Medicare, and whether medical treatment is delivered through an MOU arrangement. Alternatively, if the number of data items cannot be increased, the coding structure should be revised in the existing data element. The set of coding values could easily be expanded to eliminate important overlap among values, and a clear prioritization among types of insurance arrangements could make the element useful for both MCCF and research needs.

Status: This recommendation was taken under consideration by the software developer for the future. The field size of the insurance file is based on industry standard configuration. The recommendation calls for expanding the file to accommodate additional provisions of the policy. Considering the requirements to obtain pre and continued certification this is not considered a high priority.

Recommendation #3: Establish VA-wide guidelines for compiling the underlying data about a veteran's insurance policies.

Status: This is considered an operational issue and remains the responsibility of each medical center and VISN to obtain insurance information upon registration and check-in.

Recommendation #4: Collect information about insurance for inpatient stays and include it in the main inpatient service file.

Status: This is the same issue as discussed in the previous recommendation.

Recommendation #5: Establish agreements with the major insurers at each station. The small number of insurers that account for a large share of total MCCF billings and collections appears to make it feasible for MCCF staff at each station to establish such agreements.

Status: Many medical centers and VISN's have informal and formal agreements with their high volume payors. Headquarters encourages medical centers and VISN's to meet with their payors and continue to develop positive working relationships with them.

Date: July 1999

Study/Report: Evaluation of the Conceptual & Methodological Foundation of the MDRC's Forecast Model for MCCR Alternative Revenues
Contractor: Systems Flow, Inc.

Recommendation: Estimate new geographic indices of private insurance and HMO penetration.

Response: VHA agrees with the recommendation. VHA uses the data suggested by the consultant that conducted the study. The data were estimates of private insurance at regional level based on National Surveys of Veterans. However, in subsequent years the data was updated to the VISN-level of private insurance coverage. The updated data was more detailed and directly linked to VA Utilization through the "1999 Veterans Health Survey."

The model continually updates the HMO market penetration information with most current data available.

Recommendation: Conduct Further Research to Identify Insurance Characteristics of VA Users

Response: The Revenue Office engaged internal VHA statisticians to conducted a two-year research project to review 1999 Veterans Health Survey data with respect to differences in utilization between insured and uninsured VA patients.

Recommendation: Conduct Further Research to Adapt Private Sector Payor Rates to VA Users

Response: Office of Revenue has convened a workgroup with participation of VA's Center for Health Quality, Outcomes, & Economic Research to consider other changes to the current approach to setting collection goals.

Recommendation: Improving Estimates of Insurance Coverage and Payor Rates

Response: The Revenue Office believes the 1999 Veterans Health Survey data is better for these purposes than the suggested data sets because it uses VA's patient population. A workgroup considered the suggested improvements along with others.

Recommendation: Using Expert Judgment to Forecast Future Collections

Response: The Office of Revenue workgroup will consider the suggested improvements along with others.

Date: Summer 1999
Study/Report: National Summary Report, Project: Preparation for Reasonable Charges
Contractor: PricewaterhouseCoopers

Recommendation: In preparation for the implementation of Reasonable Charges on September 1999, PwC put together a three-part action plan to assist VHA facilities. The three phases included the designing of a local action plan (including strategies to minimize risks, data validation, training, and insurance file data integrity), the implementation of the plan, and medical records documentation and claims review by VHA headquarters.

Status: Each of the above recommendations was concurred by the VHA CFO and communicated to the field. Monthly reports were required from the field to monitor compliance and progress. There was an initial five-month lag from the implementation of Reasonable Charges, but the field now understands the positive impact of Reasonable Charges.

Date: October 1999
Study/Report: Development of Business Plan for Outsourcing Health Care Revenue Collection
Contractor: Systems Flow, Inc.

Recommendation: Create and maintain an environment of managed competition for the performance of revenue collection. The competitors will be commercial vendors and in-house franchise operations who will contend for the opportunity to perform billing and collection activities for a VISN's medical operations. The principal measure of success will be net revenue.

Status: Implementation of a major study on the outsourcing of parts of the Revenue Cycle and development of a business office modeling pilot study in four VA hospital networks has already begun. The pilot test project is scheduled to be completed by December 2002.

Date: April 2000
Study/Report: Background Material for VA Copay Work Group
Contractor: PricewaterhouseCoopers

Recommendation: None. This was an Internet search of articles on copayment policies and practices.

Status: The VHA copayment work group used this information in their effort to develop options on copayment policy and rates.

Date: June 2000
Study/Report: Preliminary Findings on Industry Cost Sharing Practices
Contractor: PricewaterhouseCoopers

Recommendation: None. This was a review of cost sharing practices in the private and public sector in the areas of extended care services and prescription drugs.

Status: The Veterans Millennium Health Care and Benefits Act authorized VHA to develop and implement copayment methodologies and amounts for outpatient, extended care services and prescription. With this new authority, the VHA copay work group expanded their scope and information on industry trends on extended care and medication copays was necessary.

Date: September 2001
Study/Report: Veterans Health Administration Revenue Cycle Improvement Plan
Contractor: PricewaterhouseCoopers

Recommendations:

This plan outlines recommended actions required to improve the core business processes of the revenue cycle. These action items fall within the five process areas: Patient Intake, Documentation, Coding, Billing, and Accounts Receivable (AR). The work group and steering committees have identified 24 major recommendations that require action in order to bring VHA's revenue operation to the next level. Many of these actions require collaborative efforts for solutions to long-standing problematic areas of the Revenue Program. Of the 24 major proposed actions, we have identified five specific actions that represent each process area and are critical to the overall success of this improvement plan:

- Implement electronic insurance identification and verification
- Create education programs for veterans, clinical, and administrative staff
- Mandate the use of encoder and claims analyzer software
- Consolidate/outsource third-party AR follow-up
- Enforce existing national documentation policy

The key to success remains the commitment of VHA senior management to the improvement of the Revenue Program.

Performance Measures

We have proposed eight primary performance measures that would properly assess the impact and progress of each recommended action. These measures should be considered key indicators of Revenue Program performance:

- Percentage of patients pre-registered
- Percentage of completed registrations
- Percentage of insurance identified and verified prior to discharge
- Percentage of encounters with electronic notes
- Bill lag time (from care to payment)
- Percentage of third-party AR greater than 90 days

- Cost to collect
- Total collections

Critical Improvement Factors (CIF)

This plan outlines a number of VHA critical improvement factors. A shift in organization performance should come as a result of successful follow through on these factors. Such a shift should enable VHA to transform present challenges to opportunities for continued excellence. It should also improve its overall organizational performance and further its goal to increase collections:

- Shared vision for the entire organization on the role and importance of revenue collection
- Leadership commitment from all organizational elements
- Accountability and Standardization for performance and procedures
- Qualified resources in clinical documentation and medical coding
- Training and education programs for veterans and staff
- Data capture that leads to consistent, accurate performance measurement
- Information systems that support the revenue cycle
- Application of standardized policies for clinical documentation and use of technology
- Performance goals set at a national level

Consolidation & Outsourcing: Viability for Long-Term Solutions

National consolidation and outsourcing represent viable long-term solutions to enhance the performance of the VHA revenue cycle. VHA will assess and define aspects within the five core (5) process areas that should be immediately centralized and/or consolidated within VA or outside VA (e.g., contracted out). The long-term vision articulated in this plan also considers the viability of outsourcing all aspects of billing and accounts receivable as well as the patient financial/accounting system. Overall, the 24 recommended actions prescribed within this plan should enable VHA to move in this direction. To make these solutions viable, VHA will need to enlist a multifaceted approach. It will need to continue its present effort to transform the "front-end" processes in its revenue cycle to the next level. The acquisition and implementation of a Commercial-off-the-Shelf Software (COTS) package coupled with making VistA "billing aware" will further VHA's revenue cycle transformation.

Roles and Responsibilities

The success of this plan depends on the concerted effort of various administrative and clinical organizational elements within VHA. Accountability, responsibility, and authority for performance and outcomes must begin at VHA Central Office. Central Office should provide policy direction and national program support to the VISNs and VAMCs.

Central Office should hold VISN leaders and managers accountable for Revenue Program results: clearly communicating performance incentives and consequences to staff. VISN leaders should hold VAMC management accountable for performance in much the same manner.

In terms of administrative and clinical partnering, VHA believes that, as a minimum, the following offices must work together for the successful implementation of this improvement plan:

- Deputy Under Secretary for Health
- Assistant Deputy Under Secretary for Health
- VHA, Office of Patient Care Services
- VHA Office of Finance, Revenue Office
- VHA, Office of Finance, Compliance and Business Integrity Office
- VHA Office of Information, Health Information Management Service
- VHA, Health Administration Service
- VHA Office of Information, Systems Design and Development

Milestones & Accomplishments:

♦ **Developed and Implemented a Project Management Protocol**

The improvement plan makes 24 recommended actions. To accomplish the implementation of these 24 recommendations requires extensive activity and coordination among various stakeholders in the VHA. This project management protocol attempts to put in place a structure and framework from which to plan and organize this complex effort. It will be used by the identified Integrated Project Teams (IPTs) throughout the duration of each project.

Its overall purpose is to:

- To provide a consistent framework from which to manage the progress of individual projects
- To provide a consistent framework from which to report on the progress of individual projects
- To provide specific tools from which to develop and organize individual project plans

This document has three core parts. The first part describes the method and approach as well as highlights the essential requirements involved in this implementation. The second part of this document provides project plan development and reporting templates. The third part includes support documents and templates for review and consideration.

♦ **Developed and Implemented Project Plan Template**

This template is the second core element of the overall project management protocol. It will assist the Integrated Plan Teams draft their respective project plans. Its structure is dialogue based in that it poses questions to the project team the response to which results in the creation of an integrated project plan.

♦ **Organized Integrated Project Teams and Identified Project Leaders**

As prescribed under this improvement plan, VHA will assemble cross-functional integrated project teams (IPT) composed of VA Central Office and field staff to implement the plan's recommended actions. Each IPT will be responsible for one or multiple actions. The IPT approach attempts to streamline coordination and communication among various elements of VHA involved in the revenue cycle process. This approach will also promote a better understanding of the complex issues and dependencies affecting the revenue cycle process, identify better use of diminishing resources across various stakeholders, and establish process ownership and responsibility.

VHA has organized a total of six integrated plan teams to pursue the completion of the 24 recommended actions outlined in the VHA Revenue Cycle Improvement Plan. To

accomplish this implementation effort in an efficient and effective manner, we have divided it into phases -- beginning with the phase one rollout detailed specifically within this document. The phase one rollout involves 10 core actions items that are representative of the 5 critical actions noted in the improvement plan. As each project has an educational component, we have assigned an educational team lead from EES to coordinate the educational issues for each project team.

We have identified the IPTs, the IPT project managers, EES Team Lead, and the action items under the charge of each IPT.

Integrated Project Team I

Project Manager: Central Office Staff (To be determined)

Educational Team Lead: Colleen Feige
Project Focus: Mandates and Ongoing Project

Mandate pre-registration of veterans	**(Action Item # 1)**
⇒ **Develop and implement veteran educational program**	**(Action Item # 3)**
⇒ **Mandate use of encoder software**	**(Action Item #14)**
⇒ **Mandate use of "claims analyzer" tools**	**(Action Item #18)**
Mandate interface to an access policy to VistA ancillary packages	**(Action Item #16)**
**Complete implementation of EDI/MRA projects	**(Action Item # 17)**
**Implement third-party payment processing and remittance	**(Action Item #23)**

Integrated Project Team II

Project Manager: Linda Nugent
Educational Team Lead: Ann Tyler
Project Focus: Health Information Management Issues

⇒ Enforce existing national documentation policy (M-1, Part I, Chapter 5)	**(Action Item # 8)**
Develop staffing plan for qualified coding resources	**(Action Item # 13)**
Mandate use of electronic medical records (CPRS)	**(Action Item # 9)**
Develop and mandate use of electronic encounter form and documentation template	**(Action Item # 11)**
Develop and implement documentation tracking system	**(Action Item #12)**
⇒ **Develop national standard for laboratory, radiology, and other ancillary test names and corresponding**	

CPT codes **(Action Item #15)**

Integrated Project Team III

Project Manager: **Vickie Nitschke**
Educational Team Lead: **Nancy Donovan**
Project Focus: **Billing Aware Issues**

Improve the charge capture process (Action Item #19)

Conduct complete and comprehensive review of CM
=>Review/modernize clinical applications-billing aware
Modernize Charge Master
Modernize Auto Biller
Modernize Claims Tracking to support account based functions
Enhance CPRS to better support the capture of billable events

Integrated Project Team IV

Project Manager: **Pam Bostwick; Roxanne Vanover**
Educational Team Lead: **Anne Stechmann**
Project Focus: **Accounts Receivable Issues**

⇒ Consolidate/outsource third-party accounts receivable **(Action Item #20)**
Request General Counsel aggressively pursue referred accounts receivable **(Action Item #22)**
Implement AR management software **(Action Item #24)**

Integrated Project Team V

Project Manager: **James Speros**
Educational Team Lead: **Sue Hotzler**
Project Focus: **Insurance Related Issues**
Implement electronic insurance identification and verification **(Action Item #5)**
Consolidate insurance information at the enterprise level **(Action Item #6)**
Develop an employer master file **(Action Item #7)**
⇒ **Define standards for complete and accurate data capture** **(Action Item #2)**
⇒ **Develop and implement employee educational**

program on insurance **(Action Item #4)**

Integrated Project Team VI

Project Director: **Niki Gray**
Educational Team Lead: **Jeff Henry**
Project Focus: **UR Related Issues**

⇒ **Develop utilization review program** **(Action Item #21)**

Note:
⇒ -- Phase One Priority To Begin Immediately
** -- Ongoing

♦ **Integrated Project Teams' Project Directors Meeting – September 2001**

We convened a meeting in Chicago to confirm our shared understanding of the critical next steps outlined in the improvement plan. We set the parameters for the project implementation phase and defined expectations regarding project management issues, such as, project reporting and resource needs.

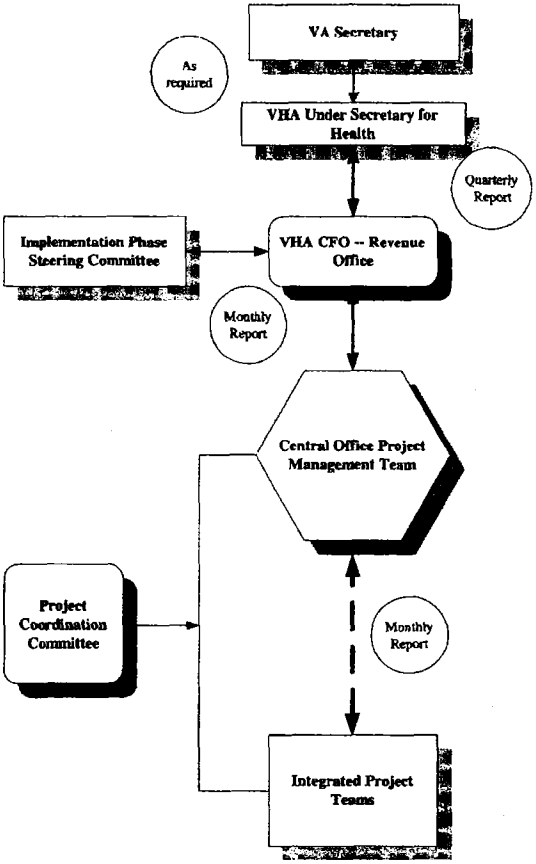
♦ **Identified and Defined Project Management Implementation Reporting Structure**

Oversight and Coordination
The meeting participants defined the purpose and resources necessary for the Steering Committee and Project Coordination Committee. Refer to the Integrated Project Plan Template for a diagram depicting the complete communication structure.

Steering Committee
The role of the Steering Committee will be to track progress of Integrated Project Teams, at a high level. More importantly, the Steering Committee will be the group to which we go for help if problems arise. This group should be comprised of many of the same individuals that served on the 90-day plan Steering Committee.

Project Coordination Team
The purpose of this group will be to coordinate resources and time lines. It should be comprised of the following individuals:
- Managers of Integrated Project Teams
- Steering Committee liaison
- Members of the Revenue Office
- OI SD&D representative
- EES representative

Implementation Phase – Project Reporting Structure



♦ Train the Trainer – Coding Boot Camp

Coding Boot Camp was held in Northern Virginia during the week of September 17, 2001. Because of the tragic events that occurred on September 11th, the camp was delayed for a week because of employee concerns about traveling. This intensive three-day session was video taped for national distribution.

- **National MCCR Conference**

A national MCCR Conference was held the week of November 5th, 2001. This conference included a training day for newly appointed (18 months or less) MCCR coordinators. The Revenue Improvement Plan was extensively discussed.

Date: September 2001
Study/Report: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections
Contractor: GAO Report, GAO-01-1157T

Summary: VA's efforts to date have not provided the data needed to compare program expenditures and collections and to choose among the major alternatives of contracting or using in-house staff for its revenue operations. Nor does VA establish net revenue as a criterion in its recent improvement plan to address weaknesses in facility managed operations and later consider the in-house staffing and contractor alternatives. Without a credible business case for increasing expenditures that result in more net revenue, VA's budget officials will be at odds regarding how to spend sizable portions of VA's resources – on revenue operations or on medical care.

While VA has used competitive sourcing to a limited extent, it could realize additional savings by competing, through the use of OMB's Circular A-76, the costs of government providing these services in-house versus the costs of buying them from the private sector. Our work at the Department of Defense shows that, by competitive sourcing under OMB Circular A-76, costs decline through increased efficiencies whether the government or the private sector wins the competition to provide services. This work indicates that savings are probable for VA, but we cannot estimate potential savings from competitive sourcing because of uncertainty regarding the availability of interested contractors, the price of contractor services, and the extent to which VA is able to decrease its operating costs in a competitive process.

A recent House Committee on Appropriations' report accompanying the fiscal year 2002 appropriations bill includes funding for VA to create a demonstration of a contractor-installed and operated financial system for revenue operations. Such a demonstration might provide an opportunity to test the contracting alternative relative to in-house alternatives. The contractor's financial system, which would supplement VA's system, would be a prototype under the demonstration. It is intended to provide functions to overcome current deficiencies in such areas as verifying insurance, accumulating all charges for care, ensuring proper coding, producing bills, and managing the collections process.

VA's current pilot has consolidated operations at some networks, and its recent improvement plan is designed to improve in-house operations over about a 2-year period. If VA then gathered appropriate information on net revenues and other key outcomes for these alternatives, it would be better positioned to make a fact-based decision among them in a manner envisioned by OMB A-76.

Post Hearing Question
Concerning September 20, 2001, Hearing
For the Honorable Thomas L. Garthwaite, M.D.
Under Secretary for Health
Department of Veterans Affairs
From Congressman Michael Bilirakis
House Committee on Veterans Affairs
Subcommittee on Oversight and Investigations

Question 1: Earlier this year, an adjustment of funding in the Veterans Health Administration (VHA) resulted in the recall of eleven million dollars from the current budget in Veterans Integrated Service Network (VISN) 8 and sixteen million dollars in VISN 16. Since both of the VISNs serve the veterans from my home state, I have been greatly concerned about the negative impact this recall will have on the availability of health care for Florida's veterans.

Because of the rescission, the Florida network had to delay the opening of several community-based outpatient clinics (CBOCs).

From the data I have received, the Florida network does a pretty good job collecting third-party reimbursements. I also understand that some VISNs are projecting deficits for next year.

Are steps being taken to increase MCCF collections or increase other efficiencies in this VISN so that other networks will not have another recall of their funds?

Answer: The Veterans Health Administration (VHA) faces financial challenges in FY 2002 and beyond due to a variety of reasons. We are currently developing a strategy to assure fiscal solvency for FY 2002, and to position VHA to meet its long-term goal of providing high quality health care and maintaining its commitment to the highest priority veterans. Within this fiscal strategy we will ensure that all VISNs will achieve efficiencies. We will ensure that any VISN that needs supplemental funding will receive it as part of the FY 2002 allocation process, thus eliminating the need to recall funds after allocation.

VA is planning to implement the increase in the medication co-payment. This should occur in FY 2002. Collections from the medication co-payment increase are projected to increase by $225 million in FY 2002 and $300 million in FY 2003. Also, VHA is working with the VISNs to improve the overall collection process. This includes subcontracting out specific aspects of the revenue process where skilled staff members are not available or are in the process of being trained, i.e. Accounts Receivable follow-up and coding. Additionally, VHA has a number of pilot projects with vendors to assist in the identification of insurance benefits of veterans who seek treatment. VHA is also exploring the use of automated processes to improve the accuracy and integrity of claims through claims analyzers and encoders. The use of these tools will assist VHA in creating a more accurate bill to an insurance company for payment. We have also developed a First Party Lockbox process that enables the VA to receive and deposit payments from individuals on a timely basis. VA has been consistently diligent in the collection of funds due VA from health insurance companies and individuals and will continue to be so in the future.

Congressman Evans to Mr. James Woys, President, Health Net Federal Services

Health Net
Federal Services

James E. Woys
President

Sacramento Headquarters
2025 Aerojet Road
Rancho Cordova, CA 95742

October 12, 2001

Democratic Staff Director
Subcommittee on Oversight and Investigation
333 Cannon House Office Building
Washington, DC 20515

Dear Staff Director:

Thank you for your follow-up question to my testimony before your committee.

In those instances where we identify Third Party Liability claims; claims that Health Net Federal Services (HNFS) paid but are the responsibility of a third party payer such as an automobile, business or personal liability policy or worker's compensation coverage; HNFS is required under the Federal Medical Care Recovery Act (FMCRA) to refer these collections to the DOD Judge Advocate General (JAG) for follow up and recovery. The JAG does not advise us of the amounts recovered, however, the claims we referred to the JAG in 2000 are summarized below:

TRICARE Contract	# Claims Referred	Amount Referred
Regions 9/10/12	2,643	$11,138,892
Region 6,	676	$2,917,805
Region 11	198	$ 519,740

While TPL recoveries are referred to the JAG, HNFS identifies and recovers significant dollar amounts of Coordination of Benefits (COB) overpayments through our regular claims follow up and recovery procedures. These overpayments are identified when we update our Other Health Insurance files based on information gathered from claims being processed or by contacts with beneficiaries by our field staff. These overpayments are then collected from the providers we originally paid by offsetting the amount to be recovered against current claim payments.

In addition to our internal processes, we utilize outside claims recovery companies to identify overpayments that are not easily identified through normal overpayment recoupment efforts. Such overpayments are caused by many reasons such as hospitals billing multiple insurers for the same expense due to the lack of clarity or confusion about who is primarily and secondarily responsible for particular costs, billing errors or inadvertent overcharges for services rendered.

Annually we recover approximately $5.0 million through our internal processes and $1.5 million through outside recovery efforts.

Please feel free to contact me if you have other questions or need additional information.

Very truly yours,

James E. Woys
President
Health Net Federal Services

[illegible]

[At the time of printing the committee had not received a response to follow-up questions from Edward Gaskell.]

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C.M. BURNISH
DEMOCRATIC STAFF DIRECTOR

April 1, 2002

Mr. Edward Gaskell, President
AdvanceMed Corporation
Reston, VA 20910-6017

Dear Mr. Gaskell:

On September 28, 2001, following a hearing on the Department of Veterans' Affairs Medical Care Cost Recovery Fund, Honorable Julia Carson, Ranking Democratic Member of the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, requested you to respond to a post-hearing question regarding the experience and performance of AdvanceMed Corporation. You were asked to provide information on gross services billed to third-party insurers, gross revenues received from those billings, and the FY 2001 cost of the contract for your three largest, Federally-contracted collection efforts. (September 28, 2001, correspondence attached).

The Subcommittee has not yet received a response from you. The information would help us assess the effectiveness of billing service providers in recouping revenues from third party insurers. It would hopefully provide actual results to buttress the asserted facts regarding the effectiveness of this management approach. An explanation regarding the facts you will hopefully provide would add to the Subcommittee's understanding of this issue.

If you do not respond to the question by April 22, 2002, this fact will be annotated in the Hearing Report. You should respond to my attention by facsimile to 202-225-2034. I will confirm receipt of any correspondence within one business day. My office phone is 202-225-9756.

Sincerely,

Len Sistek, Jr.
Democratic Staff Director
Subcommittee on Oversight
and Investigations

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DEMOCRATIC STAFF DIRECTOR

September 28, 2001

Mr. Edward Gaskell
President
AdvanceMed Corporation
11710 Plaza America Drive
Reston, VA 20190-6017

Dear Mr. Gaskell:

The attached document contains follow-up questions to your testimony at the September 20, 2001, House Veterans Affairs Subcommittee hearing on the Medical Cost Collection Fund.

Please provide a written response to the questions either postmarked or faxed no later than October 14th, 2001. Please forward your response to:

Democratic Staff Director
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515
or, fax to: 202-225-2034

The questions and your responses will be included in the final hearing report.

Regards,

Julia Carson

JULIA CARSON
Ranking Democratic Member

Questions for Mr. Edward Gaskell

AdvanceMed Corporation holds contracts with several federal entities to provide services related to coding, billing, and collection of third party funds. These are essential core requirements of the VA's Medical Cost Collection Fund (MCCF) program. For your three largest, Federally-contracted collection efforts, please state the agency, the gross services billed to third party insurers, the gross revenues received from those billings, and the FY 2001 cost of the contract. Provide any further explanation as required.

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