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VA HEALTH CARE

VA Increases Third-Party Collections as It Addresses Problems in Its Collections Operations

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Highlights

Highlights of GAO-03-740T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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Why GAO Did This Study

The Department of Veterans Affairs (VA) collects health insurance payments, known as third-party collections, for veterans' health care conditions it treats that are not a result of injuries or illnesses incurred or aggravated during military service. In September 1999, VA adopted a new fee schedule, called "reasonable charges," that it anticipated would increase revenues from third-party collections.

In January 2003, GAO reported on VA's third-party collection efforts and problems in collections operations for fiscal year 2002 as well as VA's initiatives to improve collections (*VA Health Care: Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations*, [GAO-03-145, Jan. 31, 2003]). GAO was asked to discuss its findings and update third-party collection amounts and agency plans to improve collections.

What GAO Found

VA's fiscal year 2002 third-party collections rose by 32 percent over fiscal year 2001 collections, to $687 million, and available data for the first half of fiscal year 2003 show that $386 million has been collected so far. The increase in collections reflects VA's improved ability to manage the larger billing volume and more itemized bills required under its new fee schedule. VA managers in three regional health care networks attributed billings increases to a reduction of billing backlogs and improved collections processes, such as better medical documentation prepared by physicians, more complete identification of billable care by coders, and more bills prepared per biller.

Although collections are increasing, operational problems, such as missed billing opportunities, persist and continue to limit the amount VA collects. VA has been implementing the action items in its Revenue Cycle Improvement Plan of September 2001 that are designed to address operational problems, such as unidentified insurance for some patients, insufficient documentation of services for billing, shortages of billing staff, and insufficient pursuit of accounts receivable. VA reported in April 2003 that 10 of 24 action items are complete; 7 are scheduled for implementation by the end of 2003; and the remaining actions will begin in 2004 with full implementation expected in 2005 or 2006. These dates are behind VA's original schedule. In addition, the Chief Business Office, established in May 2002, has developed a new approach that combines the action items with additional initiatives.

Given the growing demand for care, especially from higher-income veterans, it is important that VA resolve its operational problems and sustain its commitment to maximizing third-party collections. It is also important for VA to develop a reliable estimate of uncollected dollars and a complete measure of its collections costs. Without this information, VA cannot evaluate its effectiveness in supplementing its medical care appropriation with third-party dollars.

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) progress in collecting insurance payments for care provided at VA facilities from eligible veterans' private health insurers. Known as third-party collections, these collections are VA's largest source of revenue to supplement its medical care appropriation, and they help pay for veterans' growing demand for care. The total number of veterans VA treated has increased from 2.6 million in fiscal year 1996 to 4.3 million in fiscal year 2002, and VA predicts continuing growth in its patient workload. Higher income veterans or those without service-connected disabilities have comprised a significant portion of this growth, and third-party collections are intended to help pay for the cost of their care.

Over the past several years, concerns have been raised about VA's ability to maximize its third-party collections to enhance revenues. We testified in September 2001 that problems in VA's collections operations—such as inadequate patient intake procedures to gather insurance information, insufficient physician documentation, a shortage of qualified coders, and insufficient automation—diminished VA's collections.[1] Concerned about these issues you asked that we report on (1) trends in VA's third-party collections, (2) problems in collections operations, and (3) VA's approach for improving collections. My comments today are based on a report we issued to this subcommittee on January 31, 2003.[2] For that work, we examined VA's collections data for fiscal years 2001 and 2002 and available data for 2003; reviewed relevant VA documents, such as the Veterans Health Administration's (VHA) Revenue Cycle Improvement Plan of September 2001; and interviewed officials in VA headquarters and in 3 of VA's 21 health care networks[3]—Network 2 (Albany), Network 9 (Nashville), and Network 22 (Long Beach). At your request, we updated information in that report on third-party collection amounts and agency

[1]U.S. General Accounting Office, *VA Health Care: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections*, GAO-01-1157T (Washington, D.C.: Sept. 20, 2001).

[2]U.S. General Accounting Office, *VA Health Care: Third Party Collections Rising as VA Continues to Address Problems in Its Collections Operations*, GAO-03-145 (Washington, D.C.: Jan. 31, 2003).

[3]The management of VA's hospitals and other health care facilities is decentralized to 21 regional networks.

plans to improve collections. We did our work in accordance with generally accepted government auditing standards.

In summary, VA's third-party collections for fiscal year 2002 totaled $687 million, 32 percent more than for fiscal year 2001, and available data for the first half of fiscal year 2003 show that $386 million has been collected so far. Although VA reported an increase in collections, we found that operational problems, such as missed billing opportunities, continued to limit collections. As a result, VA lacks a reliable estimate of uncollected dollars and therefore does not have the basis to assess its systemwide operational effectiveness. In May 2002, VA established the Chief Business Office (CBO) in VHA to develop a new approach for VA's collections activity. VA officials told us that CBO's approach would combine the VHA Revenue Cycle Improvement Plan of September 2001 (2001 Improvement Plan) with additional initiatives, such as the development of an automated financial system that better serves billing needs and additional performance measures and standards for overseeing collection units' activities. Since the introduction of the 2001 Improvement Plan, VA has made some progress in resolving operational problems, such as fully implementing electronic billing, mandating the use of electronic medical records, and using preregistration software. However, given today's tight budget environment, it is important that VA resolve its operational problems and sustain its attention and commitment to maximizing third-party collections.

Background

Although VA has been authorized to collect third-party health insurance payments since 1986, it was not allowed to use these funds to supplement its medical care appropriations until enactment of the Balanced Budget Act of 1997. Part of VA's 1997 strategic plan was to increase health insurance payments and other collections to help fund an increased health care workload. The potential for increased workload occurred in part because the Veterans' Health Care Eligibility Reform Act of 1996 authorized VA to provide certain medical care services not previously available to higher-income veterans or those without service-connected disabilities. VA expected that the majority of the costs of their care would be covered by collections from third-party payments, copayments, and deductibles. These veterans increased from about 4 percent of all veterans treated in fiscal year 1996 to about a quarter of VA's total patient workload in fiscal year 2002.

VA can bill insurers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. However, VA cannot bill them for health care conditions that result from military service, nor is it generally authorized to collect from Medicare or Medicaid, or from health maintenance organizations when VA is not a participating provider.

To collect from health insurers, VA uses five related processes to manage the information needed to bill and collect. The patient intake process involves gathering insurance information and verifying that information with the insurer. The medical documentation process involves properly documenting the health care provided to patients by physicians and other health care providers. The coding process involves assigning correct codes for the diagnoses and medical procedures based on the documentation. Next, the billing process creates and sends bills to insurers based on the insurance and coding information. Finally, the accounts receivable process includes processing payments from insurers and following up with insurers on outstanding or denied bills.

In September 1999, VA adopted a fee schedule, called "reasonable charges." Reasonable charges are itemized fees based on diagnoses and procedures. This schedule allows VA to more accurately bill for the care provided. However, by making these changes, VA created additional bill-processing demands—particularly in the areas of documenting care, coding that care, and processing bills per episode of care. First, VA must accurately assign medical diagnoses and procedure codes to set appropriate charges, a task that requires coders to search through medical documentation and various databases to identify all billable care. Second, VA must be prepared to provide an insurer supporting medical documentation for the itemized charges. Third, in contrast to a single bill for all the services provided during an episode of care under the previous fee schedule, under reasonable charges VA must prepare a separate bill for each provider involved in the care and an additional bill if a hospital facility charge applies.

Third-Party Collections Increased

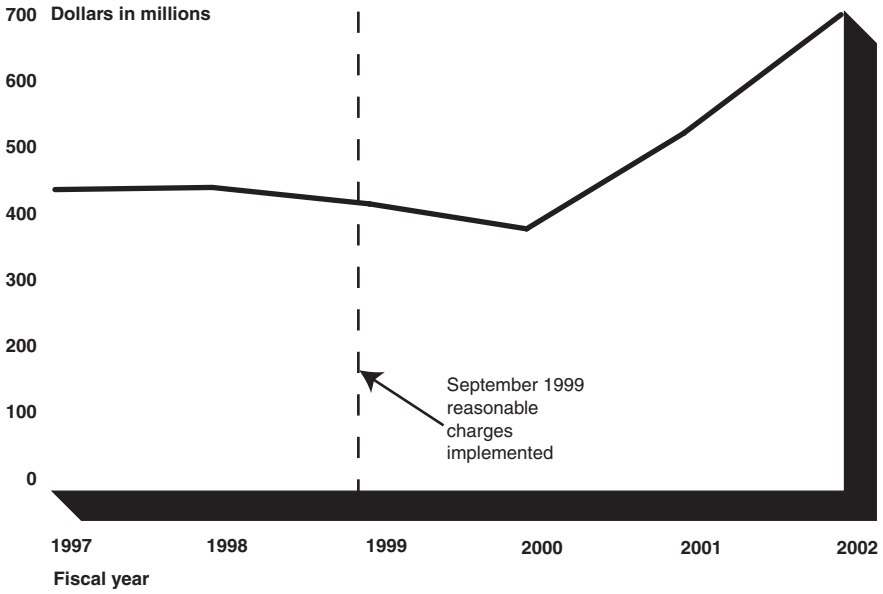
For fiscal year 2002, VA collected $687 million in insurance payments, up 32 percent compared to the $521 million collected during fiscal year 2001. Collections through the first half of fiscal year 2003 total $386 million in third-party payments. The increased collections in fiscal year 2002 reflected that VA processed a higher volume of bills than it did in the prior fiscal year. VA processed and received payments for over 50 percent more bills in fiscal year 2002 than in fiscal year 2001. VA's collections grew at a

lower percentage rate than the number of paid bills because the average payment per paid bill dropped 18 percent compared to the prior fiscal year. Average payments dropped primarily because a rising proportion of VA's paid bills were for outpatient care rather than inpatient care. Since the charges for outpatient care were much lower on average, the payment amounts were typically lower as well.

Although VA anticipated that the shift to reasonable charges in 1999 would yield higher collections, collections had dropped in fiscal year 2000. VA attributed that drop to its being unprepared to bill under reasonable charges, particularly because of its lack of proficiency in developing medical documentation and coding to appropriately support a bill. As a result, VA reported that many VA medical centers developed billing backlogs after initially suspending billing for some care.

As shown in figure 1, VA's third-party collections increased in fiscal year 2001—reversing fiscal year 2000's drop in collections—and increased again in fiscal year 2002. After initially being unprepared in fiscal year 2000 to bill reasonable charges, VA began improving its implementation of the processes necessary to bill and increase its collections. By the end of fiscal year 2001, VA had submitted 37 percent more bills to insurers than in fiscal year 2000. VA submitted even more in fiscal year 2002, as over 8 million bills—a 54 percent increase over the number in fiscal year 2001—were submitted to insurers.

Figure 1: VA's Third-Party Collections, Fiscal Years 1997 through 2002



Source: VA.

Managers we spoke with in three networks—Network 2 (Albany), Network 9 (Nashville), and Network 22 (Long Beach)—mainly attributed the increased billings to reductions in the billing backlogs. Networks 2 (Albany) and 9 (Nashville) reduced backlogs, in part by hiring more staff, contracting for staff, or using overtime to process bills and accounts receivable. Network 2 (Albany), for instance, managed an increased billing volume through mandatory overtime. Managers we interviewed in all three networks noted better medical documentation provided by physicians to support billing. In Network 22 (Long Beach) and Network 9 (Nashville), revenue managers reported that coders were getting better at identifying all professional services that can be billed under reasonable charges.[4] In addition, the revenue manager in Network 2 (Albany) said that billers' productivity had risen from 700 to 2,500 bills per month over a 3-year

[4]The revenue manager in Network 9 (Nashville) said that coders were getting better at the manual searching that is required to find billable professional services and laboratory tests. During fiscal year 2001, coders missed some billable care because of inadequate searches through the various sources of information used to document services and tests.

period, as a result of gradually increasing the network's productivity standards and streamlining their jobs to focus solely on billing.

VA officials cited other reasons for the increased number of bills submitted to insurers. An increased number of patients with billable insurance was one reason for the increased billing. In addition, a May 2001 change in the reasonable-charges fee schedule for medical evaluations allowed separate bills for facility charges and professional service charges, a change that contributed to the higher volume of bills in fiscal year 2002.

Operational Problems Limit Collections, but VA Lacks an Estimate of Uncollected Dollars

Studies have suggested that operational problems—missed billing opportunities, billing backlogs, and inadequate pursuit of accounts receivable—limited VA's collections in the years following the implementation of reasonable charges. For example, a study completed last year estimated that 23.8 percent of VA patients in fiscal year 2001 had billable care, but VA actually billed for the care of only 18.3 percent of patients.[5] This finding suggests that VA could have billed for 30 percent more patients than it actually billed. Further, after examining activities in fiscal years 2000 and 2001, a VA Inspector General report estimated that VA could have collected over $500 million more than it did.[6] About 73 percent of this uncollected amount was attributed to a backlog of unbilled medical care; most of the rest was attributed to insufficient pursuit of delinquent bills. Another study, examining only professional-service charges in a single network, estimated that $4.1 million out of $4.7 million of potential collections was unbilled for fiscal year 2001.[7] Of that unbilled amount, 63 percent was estimated to be unbillable primarily because of insufficient documentation. In addition, the study found that coders often missed services that should have been coded for billing.

According to a CBO official, VA could increase collections by working on operational problems. These problems included unpaid accounts receivable and missed billing opportunities due to insufficient

[5]T. Michael Kashner, Ph.D., J.D., et al., *Final Report: Veterans Affairs Patient Health Insurance Survey (VAPHIS)*, a survey funded by the Department of Veterans Affairs, February 16, 2002.

[6]Department of Veterans Affairs, Office of Inspector General, *Audit of the Medical Care Collection Fund Program*, Report No. 01-00046-65 (Washington, D.C.: Feb. 26, 2002).

[7]Economic Systems, Inc. and AdvanceMed, *Professional Fee Backlog Assistance: Final Technical Report*, a report prepared for the Department of Veterans Affairs, March 5, 2002.

identification of insured patients, inadequate documentation to support billing, and coding problems that result in unidentified care. From April through June 2002, three network revenue managers told us about backlogs and processing issues that persisted into fiscal year 2002. For example, although Network 9 (Nashville) had above average increases in collections for both inpatient and outpatient care, it still had coding backlogs in four of six medical centers. According to Network 9's (Nashville) revenue manager, eliminating the backlogs for outpatient care would increase collections by an estimated $4 million, or 9 percent, for fiscal year 2002.[8] Additional increases might come from coding all inpatient professional services, but the revenue manager did not have an estimate because the extent to which coders are capturing all billable services was unknown. Moreover, although all three networks reported that physicians' documentation for billing was improving, they also reported a continuing need to improve physicians' documentation. In addition, Network 22 (Long Beach) reported that its accounts receivable staff had difficulties keeping up with the increased volume of bills because it had not hired additional staff members or contracted help on accounts receivable.

As a result of these operational limitations, VA lacks a reliable estimate of uncollected dollars, and therefore does not have the basis to assess its systemwide operational effectiveness. For example, some uncollected dollars result from billing backlogs and billable care missed in coding. In addition, VA does not know the net impact of actual third-party collections on supplementing its annual appropriation for medical care. For example, CBO relies on reported cost data from central office and field staff directly involved in billing and collection functions. However, these costs do not include all costs incurred by VA in the generation of revenue. According to a CBO official, VA does not include in its collections cost the investments it has made in information technology or resources used in the identification of other health insurance during the enrollment process.

[8]In September 2002, the revenue manager anticipated that the backlog would be reduced to $2 million by the end of fiscal year 2002 because the medical centers had hired new coders and the network had created a central pool of seven coders.

2001 Plan to Improve Collections Is Partially Implemented; Other Initiatives Being Developed

VA continues to implement its 2001 Improvement Plan, which is designed to increase collections by improving and standardizing VA's collections processes. The plan's 24 actions are to address known operational problems affecting revenue performance. These problems include unidentified insurance for some patients, insufficient documentation for billing, coding staff shortages, gaps in the automated capture of billing data, and insufficient pursuit of accounts receivable. The plan also addresses uneven performance across collection sites.

The plan seeks increased collections through standardization of policy and processes in the context of decentralized management, in which VA's 21 network directors and their respective medical center directors have responsibility for the collections process. Since management is decentralized, collections procedures can vary across sites. For example, sites' procedures can specify a different number of days waited until first contacting insurers about unpaid bills and can vary on whether to contact by letter, telephone, or both. The plan intends to create greater process standardization, in part, by requiring certain collections processes, such as the use of electronic medical records by all networks to provide coders better access to documentation and legible records.

When fully implemented, the plan's actions are intended to improve collections by reducing operational problems, such as missed billing opportunities. For example, two of the plan's actions—requiring patient contacts to gather insurance information prior to scheduled appointments and electronically linking VA to major insurers to identify patients' insurance—are intended to increase VA's awareness of its patients who have other health insurance.

VA has implemented some of the improvement plan's 24 actions, which were scheduled for completion at various times through 2003, but is behind the plan's original schedule. The plan had scheduled 15 of the 24 actions for completion through May 25, 2002, but as of that date VA had only completed 8 of the actions. Information obtained from CBO in April 2003 indicates that 10 are complete and 7 are scheduled for implementation by the end of 2003. Implementation of the remaining actions will begin in 2004 as part of a financial system pilot with full

implementation expected in 2005 or 2006.[9] (Appendix I lists the actions and those VA reports as completed through April 28, 2003.)

In May 2002, VHA established its CBO to underscore the importance of revenue, patient eligibility, and enrollment and to give strategic focus to improving these functions. Officials in the office told us that they have developed a new approach for improving third-party collections that can help increase revenue collections by further revising processes and providing a new business focus on collections.

For example, the CBO's strategy incorporates improvements to the electronic transmission of bills and initiation of a system to receive and process third-party payments electronically. CBO's new approach also encompasses initiatives beyond the improvement plan, such as the one in the Under Secretary for Health's May 2002 memorandum that directed all facilities to refer accounts receivable older than 60 days to a collection agency, unless a facility can document a better in-house process. According to the Deputy Chief Business Officer, the use of collection agencies has shown some signs of success—with outstanding accounts receivables dropping from $1,378 million to $1,317 million from the end of May to the end of July 2002, a reduction of about $61 million or 4 percent.

CBO is in the process of acquiring a standardized Patient Financial Services System (PFSS) that could be shared across VA. VA's goal with PFSS is to implement a commercial off-the-shelf health care billing and accounts receivable software system. Under PFSS, a unique record will be established for each veteran. Patient information will be standardized—including veteran insurance data, which will be collected, managed, and verified. Receipts of health care products and services will be added to the patient records as they are provided or dispensed. And PFSS will automatically extract needed data for billing, with the majority of billings sent to payers without manual intervention. After the system is acquired, VA will conduct a demonstration project in Network 10 (Cincinnati).[10]

[9]One action item was cancelled but its intended improvements will be incorporated into an automated financial system initiative.

[10]In the conference report accompanying its fiscal year 2002 appropriation, VA was directed to begin a demonstration project of a patient financial services system installed and operated by a contractor. H.R. Conf. Rep. No. 107-272, at 56 (2001).

According to the Deputy Chief Business Officer, in May 2003 VA anticipates awarding a contract for the development and implementation of PFSS. CBO's plan is to install this automated financial system in other facilities and networks if it is successfully implemented in the pilot site.

CBO is taking action on a number of other initiatives to improve collections, including the following:

- Planning and developing software upgrades to facilitate the health care service review process and electronically receive and respond to requests from insurers for additional documentation.
- Establishing the Health Revenue Center to centralize preregistration, insurance identification and verification, and accounts receivable activities. For example, during a preregistration pilot in Network 11 (Ann Arbor), the Health Revenue Center made over 246,000 preregistration telephone calls to patients to verify their insurance information. According to VA, over 23,000 insurance policies were identified, resulting in $4.8 million in collections.
- Assessing its performance based on private sector performance metrics, including measuring the pace of collections relative to the amount of accounts receivable.

Concluding Observations

As VA faces increased demand for medical care, particularly from higher-income veterans, third-party collections for nonservice-connected conditions remain an important source of revenue to supplement VA's appropriations. VA has been improving its billing and collecting under a reasonable-charges fee schedule it established in 1999, but VA has not completed its efforts to address problems in collections operations. In this regard, fully implementing the 2001 Improvement Plan could help VA maximize future collections by addressing problems such as missed billing opportunities. CBO's initiatives could further enhance collections by identifying root causes of problems in collections operations, providing a focused approach to addressing the root causes, establishing performance measures, and holding responsible parties accountable for achieving the performance standards.

Our work and VA's continuing initiatives to improve collections indicate that VA has not collected all third-party payments to which it is entitled. In this regard, it is important that VA develop a reliable estimate of uncollected dollars. VA also does not have a complete measure of its full collections costs. Consequently, VA cannot determine how effectively it supplements its medical care appropriation with third-party collections.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the subcommittee may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact Cynthia A. Bascetta at (202) 512-7101. Michael T. Blair, Jr. and Michael Tropauer also contributed to this statement.

Appendix I: 2001 Improvement Plan Status as of April 28, 2003

Process		2001 Improvement Plan actions and intended outcomes	Actions designated as completed
Patient intake	1.	Mandate preregistration contact of veterans to verify or update insurance information prior to a scheduled appointment.[a]	●
	2.	Define standards for patient registration data to ensure capture of the information needed for billing.	
	3.	Develop and implement veteran education program to better inform veterans about the importance of providing accurate insurance information.	●
	4.	Develop and implement employee education program to provide techniques for requesting patient information and help employees understand the importance of gathering it.	
	5.	Implement electronic insurance identification and verification to more completely identify all patients' insurance and provide more timely verification of insurance policy information.	
	6.	Consolidate insurance information to provide a national resource for indentifying and verifying patient insurance information and limit redundancies in patient intake activities nationally.	
	7.	Develop an employer master file to aid insurance identification based on the patient's employer.	b
Medical documentation	8.	Enforce national documentation policy to improve the quality and timeliness of documentation and reduce the time required to bill.	
	9.	Mandate the use of electronic medical records to improve access to, and legibility of, the information needed for determining medical codes and charges.[a]	●
	10.	Develop national program to educate clinicians about documentation and coding skills and their role in collections.	●
	11.	Develop and mandate the use of electronic patient encounter forms and documentation templates to better ensure complete documentation to support billing.[a]	●
	12.	Develop and implement tracking system to monitor timely completion of documentation.	
Coding	13.	Develop plan to address current coding staff deficiencies in order to increase the accuracy and speed of coding.	●
	14.	Mandate the use of encoder software, which provides electronic assistance for accurate coding.[a]	●
	15.	Develop national standard for laboratory, radiology, and other test names and corresponding medical procedure codes to allow more consistent, accurate, and timely coding.	
Billing	16.	Mandate minimum access for billing staff to electronic information for laboratory, radiology, and surgery events, which allows for identification of more billable events.[a]	●
	17a.	Complete implementation of the electronic billing project to electronically detect billing errors and speed the delivery of bills to insurers.	c
	b.	Complete implementation of the Medicare Remittance Advice project, which allows the Department of Veterans Affairs to more appropriately bill Medigap and Medicare supplemental insurers.	
	18.	Implement "claims analyzer" tools, which can identify data and coding errors when a bill is created.	●
	19.	Improve the charge capture process in such areas as automated bill creation and identification of billable events.	
Accounts receivable	20.	Consolidate or outsource accounts receivable follow-up in a onetime effort to collect older accounts receivable.	
	21.	Develop utilization review program to educate staff on how to support the revenue process, including appeals of payment denials.	
	22.	Request VA General Counsel to more aggressively pursue "referred" third-party accounts receivable to collect on outstanding bills.	●
	23.	Implement electronic insurance payments for more efficient and lower-cost processing of payments.	
	24.	Implement software for the effective management of accounts receivable to increase collections.	

Source: VA.

[a]Certain actions are mandated in the plan, that is, are required, but these actions are not legal or regulatory mandates.

[b]One action item was cancelled but its intended improvements will be incorporated into an automated financial system initiative.

[c]VA designated the electronic billing project, shown here as "17a," as completed. However, this indicated only partial completion of action 17, which includes an additional project.

Related GAO Products

VA Health Care: Third Party Collections Rising as VA Continues to Address Problems in Its Collections Operations. GAO-03-145. Washington, D.C.: January 31, 2003.

VA Health Care: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections. GAO-01-1157T. Washington, D.C.: September 20, 2001.

VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain. GAO/HEHS-99-124. Washington, D.C.: June 11, 1999.

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