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Testimony

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

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VA MEDICAL CENTERS

Internal Control  
Weaknesses Impair  
Third-Party Collections

Statement of McCoy Williams,  
Director, Financial Management and Assurance





Highlights of [GAO-04-967T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

In the face of growing demand for veterans' health care, GAO and the Department of Veterans Affairs Office of Inspector General (OIG) have raised concerns about the Veterans Health Administration's (VHA) ability to maximize its third-party collections to supplement its medical care appropriation. GAO has testified that inadequate patient intake procedures, insufficient documentation by physicians, a shortage of qualified billing coders, and insufficient automation diminished VA's collections. In turn, the OIG reported that VA missed opportunities to bill, had billing backlogs, and did inadequate follow-up on bills. While VA has made improvements in these areas, GAO was asked to review internal control activities over third-party billings and collections at selected medical centers to assess whether they were designed and implemented effectively.

GAO's report on this issue, [GAO-04-739](#), released concurrently with this testimony, makes five recommendations to augment actions already underway to facilitate more timely billings and improve collection operations.

[www.gao.gov/cgi-bin/getrpt?GAO-04-967T](http://www.gao.gov/cgi-bin/getrpt?GAO-04-967T).

To view the full product, including the scope and methodology, click on the link above. For more information, contact McCoy Williams at (202) 512-6906 or [williamsm1@gao.gov](mailto:williamsm1@gao.gov).

# VA MEDICAL CENTERS

## Internal Control Weaknesses Impair Third-Party Collections

### What GAO Found

VA has continued to take actions to reduce billing times and increase third-party collections. VA reported that its collections of third-party payments increased from \$540 million in fiscal year 2001 to \$804 million in fiscal year 2003. However, at the three medical centers visited, GAO found continuing weaknesses in the billings and collections processes that impair VA's ability to maximize the amount of dollars paid by third-party insurance companies. For example, the three medical centers did not always bill insurance companies in a timely manner. Medical center officials stated that inability to verify and update patients' third-party insurance, inadequate documentation to support billings, manual processes and workload continued to affect billing timeliness.

The detailed audit work at the three facilities GAO visited also revealed inconsistent compliance with follow-up procedures for collections. For example, collections were not always pursued in a timely manner and partial payments were accepted as payments in full, particularly for Medicare secondary insurance companies, rather than pursuing additional collections.

VA's current Revenue Action Plan (Plan) includes 16 actions designed to increase collections by improving and standardizing collections processes. Several of these actions are aimed at reducing billing times and backlogs. Specifically, medical centers are updating and verifying patients' insurance information and improving health care provider documentation. Further, hiring contractors to code and bill old cases is reducing backlogs. In addition to actions taken, VA has several other initiatives underway. For example, VA is taking action to enable Medicare secondary insurance companies to determine the correct reimbursement amount, which will strengthen VA's position to follow up on partial payments that it deems incorrect. Although implementation of the Plan could improve VA's operations and increase collections, many of its actions will not be completed until at least fiscal year 2005. As a result, it is too early to determine the extent to which actions in the Plan will address operational problems and increase collections.

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Mr. Chairman:

I am pleased to be here today to discuss internal controls over VHA's third-party billings and collections.

First, I would like to recognize VA's continued efforts to increase third-party collections, which have increased from \$540 million in fiscal year 2001 to \$804 million in fiscal year 2003. However, in the face of growing demand for veterans' health care, GAO and the Department of Veterans Affairs Office of Inspector General have raised concerns about the Veterans Health Administration's (VHA) ability to maximize its third-party collections to supplement its medical care appropriation. In September 2001, we testified that problems in VA's collection operations—such as inadequate patient intake procedures to gather insurance information, insufficient physician documentation of the specific care provided, a shortage of qualified coders, and insufficient automation—diminished VA's collections.<sup>1</sup> In February 2002, the VA OIG reported that VA missed billing opportunities, had billing backlogs, and did inadequate follow-up on accounts receivable in fiscal years 2000 and 2001.<sup>2</sup> In May 2003 we testified that VA had made improvements in these areas but that operational problems, such as unpaid accounts receivable, missed billing opportunities, and billing backlogs continued to limit the amount VA collects.<sup>3</sup>

In conjunction with this revenue-enhancing responsibility, you asked us to review internal control activities over third-party billings and collections at selected VHA medical centers to assess whether internal controls are designed and implemented effectively. Our report on this issue is being released today at this hearing.<sup>4</sup>

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<sup>1</sup>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).

<sup>2</sup>VA Office of Inspector General, *Audit of the Medical Care Collection Fund Program*, Report No. 01-00046-65 (Washington, D.C.: Feb. 26, 2002).

<sup>3</sup>U.S. General Accounting Office, *VA Health Care: VA Increases Third-Party Collections as It Addresses Problems in Its Collections Operations*, [GAO-03-740T](#) (Washington, D.C.: May 7, 2003).

<sup>4</sup>U.S. General Accounting Office, *VA Medical Centers: Further Operational Improvements Could Enhance Third-Party Collections*, [GAO-04-739](#) (Washington, D.C.: July 19, 2004).

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You also asked that we review internal control activities in three areas of operation at selected VHA medical centers—accountability over personal property, drugs returned for credit, and part-time physician time and attendance. That report is also being issued today. At your request we also reviewed VHA's purchase card program for fiscal year 2002 and our report was issued June 7, 2004.

In my testimony today, I will discuss continuing weaknesses in the billings and collections processes that impair VA's ability to maximize the amount of dollars paid by third-party insurance companies. The scope of our work, which was performed from March 2004 through June 2004 in accordance with generally accepted government auditing standards, is detailed in the report being released today.

Heads of agencies are required to establish systems of internal control consistent with our *Standards for Internal Control in the Federal Government*.<sup>5</sup> Effective internal controls are the first line of defense in safeguarding assets and in preventing and detecting fraud. In addition, they help to ensure that actions are taken to address risks and are an integral part of an entity's accountability for the stewardship of government resources.

As I will discuss in my testimony, we found at the three medical centers visited that internal controls were not designed to provide reasonable assurance that medical centers billed insurance companies in a timely manner or consistently complied with follow-up procedures for collections. We focused on billing transactions that occurred in the first quarter of fiscal year 2004 at the Cincinnati, OH; Tampa, FL; and Washington, D.C. medical centers.

I will first discuss the results of our review over billing timeliness. Then I will discuss control weaknesses in collection activities that hamper VA's ability to collect all monies due to the agency from third-party insurance companies for veterans' care. And finally, I will highlight some of VA's initiatives to increase collections from third-party insurance companies.

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<sup>5</sup> U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

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## Operational Enhancements Could Improve Timeliness of Billings

While VA reported that it has decreased the average number of days it takes to bill for patient services, we found that medical centers could further improve billing timeliness by continuing to address operational problems that slow down the process. These operational problems include, among other things, delays in verifying and updating patient insurance information, incomplete or inaccurate documentation of patient care by health care providers, manual intervention, and workload. VA's billing process cuts across four functional areas, from patient intake, to medical documentation of treatment, to coding the treatment accurately prior to billing. Each phase of the billing process is dependent on the completeness and accuracy of information collected in the prior phases. Breakdowns occurring during any part of the process can affect the timeliness of billings.

VA's policies and procedures do not specify the number of days for a bill to be issued once health care services are rendered. In fiscal year 2003, VA's Business Oversight Board established performance goals<sup>6</sup> that were incorporated into the network and medical directors' performance contracts. The goal for sending a bill within a set number of days was reduced periodically during fiscal year 2004. During the time of our review, the performance goal for billing third party insurance companies was an average of 50 days from the date of patient discharge. As of the end of the first quarter of fiscal year 2004, the average days to bill third parties for Tampa, Washington, D.C. and Cincinnati were 73, 69, and 44 respectively.

At each of the three medical centers visited, we made a non-representative selection of 30 patients billed during the first quarter of fiscal year 2004. In evaluating the timeliness of billing, we used the performance standard then in effect of 50 days after patient discharge. We recognize that the cumulative billing times for the 90 cases selected do not represent the average days to bill, which VHA uses to measure each medical center's performance. However, cases billed more than 50 days after patient discharge are illustrative of problematic issues that can delay billings. For the 90 cases selected, the number of days to bill at the three medical centers we visited ranged from 5 to 332 days, with almost 30 percent billed after 50 days.

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<sup>6</sup>Billing performance goals (e.g. 50 days from the date of patient discharge) are computed as averages for designated time frames. Days to bill are calculated from the billing date back to the date when the patient was discharged.

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Promptly invoicing insurance companies for care provided is a sound business practice and should result in improved cash flow for VA. Officials at each of the three medical centers cited verifying and updating patients' third-party insurance information as a continuing impediment to billing third-party insurance companies in a timely manner. They told us that this occurs because, among other reasons, some patients are reluctant to provide insurance information for fear that their insurance premiums will increase. Patients delay providing insurance information until well after commencement of treatment and do not always provide current information. Thus, additional time is required to research and verify the patients' insurance coverage.

Medical center officials also told us that incomplete or inaccurate documentation from health care providers continues to cause delays in billing third parties. If the coders do not have sufficient data from the provider to support a bill, the coding process can be delayed, thus hampering timely billing of third-party insurance companies. Further, without complete data on the actual health care services provided, the coders may also miscode the treatment, which could result in lost revenue.

Another impediment to timely billing is that the billing process is not fully automated and manual intervention is required. For example, in certain cases, the medical diagnosis is transcribed onto a worksheet to be used for coding rather than being electronically transmitted. Additionally, before the coders can begin the coding process, they must first electronically download the listing of potential billable patients. Then the coders review the electronic medical records and assign diagnostic and procedure codes before a bill is generated. Further, due to system limitations, bills that exceed a certain dollar amount or number of medical procedure codes must be printed and mailed rather than transmitted electronically. For example, in Cincinnati bills greater than \$100,000 or that have six or more medical procedure codes must be processed this way.

Another contributing factor may be the workload levels at the medical centers. During the second quarter of fiscal year 2004, Cincinnati submitted 45,883 bills and had a staff of 13 coders. Concurrently, Tampa submitted 192,407 bills and had 16 coders and Washington, D.C. issued 64,474 bills and had 8 coders. VHA data indicated that Cincinnati's average billing time was under 50 days for the quarter and had the lowest bill to coder ratio. Conversely, Tampa and Washington, D.C. exceeded the 50-day performance goal and had a much higher bill to coder ratio. Assuming 60

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workdays per quarter, we calculated the ratio of bills issued per day to the number of coders and found:

- Cincinnati with 765 bills per day, 13 coders, and a ratio of 59 bills to 1 coder,
- Washington, D.C., with 1,075 bills per day, 8 coders, and a ratio of 134 bills to 1 coder, and
- Tampa, with 3,207 bills per day, 16 coders, and a ratio of 200 bills to 1 coder.

We recognize that other factors such as the number of billable encounters per bill and coder productivity may affect the billing workload. However, given the wide diversity of the bill to coder ratios, staffing may also be a contributing factor affecting days to code and issue bills.

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## VA's Controls over Collections Need Strengthening

Weaknesses in collection activities hamper VA's ability to collect all monies due to the agency from third-party insurance companies for veterans' care. We found that the three medical centers we visited did not always pursue collections of accounts receivable in a timely manner or follow up on certain partially paid insurance claims. These two factors could negatively affect third-party collections.

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## Accounts Receivable Not Pursued in a Timely Manner

VA's Handbook sets forth the requirements for collection of third-party accounts receivables.<sup>7</sup> Also, in 2003, the VHA's Chief Business Office issued the *Accounts Receivable Third-Party Guidebook* that lays out more detailed procedures.<sup>8</sup> Both documents require that once a claim has been sent to the insurance company, staff should follow up on unpaid reimbursable insurance cases as follows:

- The first telephone follow-up is to be initiated within 30 days after the initial bill is generated. All telephone follow-ups are to be documented to include, at a minimum, the name, position, title and telephone

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<sup>7</sup>VA Handbook 4800.14, *Medical Care Debts*, Department of Veterans Affairs, (Washington, D.C.: Dec. 8, 2003).

<sup>8</sup>*Accounts Receivable Third-Party Guidebook*, Department of Veterans Affairs, 2003.

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number of the person contacted, the date of contact, appropriate second follow-up date if payment is not received, and a brief summary of the conversation.

- A second telephone follow-up on unresolved outstanding receivables is to be made on an appropriate (but unspecified) date and documented.
- A third follow-up call is to be made within 14 days of the second contact and documented with a summary of the conversation and an appropriate, but not specified, follow-up date.
- If no payment has been received by the next follow-up date, the case may be referred by the Medical Care Collection Fund (MCCF) Coordinator to regional counsel for further action.

We tested compliance with these policies for the same 30 cases selected for our billing tests at each of the three medical centers we visited. Regarding the first follow-up procedure, initial calls were made within 30 days for only 14, or about 22 percent, of the 64 cases for which billings had not been collected within 30 days.

Second follow-up phone calls were not made in a timely manner either. We considered 15 days after the initial follow-up of 30 days to be an appropriate time frame since the third follow-up is to be made within 14 days after the second follow-up and cases are to be referred to collection agencies after 60 days. Delays in making second follow-up calls increase the risk that payments will not be collected. Within our selected cases, four second follow-up calls were either made more than 15 days after the first call or not at all. These bills had not been paid within 120 days after the bill was sent to the insurance company.

Both the first and second follow-up calls require that staff document the contact's name, title, telephone number, and expected follow-up date in the official records. However, we found that staff did not consistently do so. For example, for the 14 cases where a follow-up call was made during the first 30 days after the initial billing, only seven specified a follow-up date. Entering a follow-up date would serve as a reminder to make the second follow-up call. Further, we found that an unclear collection policy may have contributed to VA's untimely second follow-up efforts. Specifically, VA's Handbook requires that second follow-up telephone calls on unresolved outstanding receivables be made on an "appropriate date," but that date is not specified (i.e., the number of days elapsed since the first contact).



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Specifying a follow-up date (i.e., 15 days after the first follow-up) or providing criteria for selecting an appropriate follow-up date would clarify this requirement and provide a benchmark on which compliance could be measured.

Medical center officials at the three sites we visited told us that staff shortages and a heavy workload contributed to noncompliance with follow-up procedures. For example, Tampa officials told us that the accounts receivable staff typically have over 1,000 cases needing follow-up at any one time. The Cincinnati MCCF supervisor told us that if two additional staff were available, they would be dedicated to following up on delinquent payments.

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### Not Following Up on Partially Paid Claims Reduces the Possibility of Collecting Additional Revenue

During our review of the 90 selected cases, we noted wide variances between the amounts billed and amounts received for patients who were eligible for Medicare benefits. For example, in one of our selected cases, VA billed the secondary insurance company for \$60,994 but received only \$5,205, or about 9 percent.

In non-Medicare cases, when the patient has primary and secondary insurance, VHA bills the primary insurance company and, depending on the amount collected, bills the secondary insurance company for the residual amount. Conversely, for Medicare patients who have secondary insurance (i.e., Medigap or Medicare Supplemental insurance), VA is entitled to receive payment only from the secondary insurance company because Medicare is generally not required to and thus does not pay VA. However, VA has not been able to determine the residual amount that the secondary insurance company is responsible for paying because it lacks processes and procedures for calculating the amount that would be paid based on post-Medicare payment information (i.e., deductible and co-insurance amounts). In such cases, VA bills the secondary insurance company for the full amount associated with the care provided—the amount that would be reimbursable by Medicare as well as the amount not covered by Medicare.

The secondary insurance companies have been using a variety of methodologies for reimbursing VA and some do not pay because they are unable to determine the proper amount of reimbursement. As a result, in certain cases, VA receives very little, if any, reimbursement from the secondary insurance companies for such billings.

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The Handbook describes procedures for following up on partial payments from insurance companies. It states that payment by a third-party insurance company of an amount which is claimed to be the full amount payable under the terms of the applicable insurance policy or other agreement will normally be accepted as payment in full. The unpaid balance is to be written down to zero. However, if there is a considerable difference between the amount collected and the amount billed, the Handbook directs staff to take various actions to pursue potential additional revenue. At each of the three medical centers, we found that accounts receivable staff typically accepted partial payments from secondary insurance companies as payment in full and wrote down the unpaid balance to zero. Because the medical centers do not have the post-Medicare information needed to pursue collection of the unpaid amounts, VA may not be collecting millions of dollars because partial payments are accepted as payment in full.

VA reported that as of September 2003, the median age of all living veterans was 58 years, with the number of veterans 85 years of age and older totaling nearly 764,000. As these veterans age, the demand for care will increase, as will the number of veterans eligible for Medicare. To be able to offset the cost of care through third-party collections, it will be imperative in the coming years for VA to collect the maximum amount possible from secondary insurance companies.

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## VA Initiatives Are Under Way to Address Operational Problems

VA's current Revenue Action Plan includes 16 actions designed to increase collections by improving and standardizing the collections processes. Several of these actions are aimed at reducing billing times and backlogs, many of which have already been implemented. Specifically, medical centers are updating and verifying patients' insurance information and improving health care provider documentation. In addition, hiring contractors to code and bill old cases is reducing backlogs. Further, the introduction of performance measures into managers' performance contracts has provided an incentive for increased billings and collections. In addition to those actions already taken, VA has other initiatives under way such as automating the billing process by implementing the Patient Financial Services System and determining the amounts billable to Medicare secondary insurance companies through the use of an electronic Medicare Remittance Advice.

To assist in updating and verifying patients' insurance information, each site now has staff dedicated to (1) verify that insurance reported by the

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veteran is current, (2) determine insurance coverage if the patient does not declare any, (3) acquire pre-certifications of patient admissions, and (4) obtain authorization of procedures from the patient's insurance company. Additionally, medical centers have taken actions to update demographic information on file, including insurance. These efforts help to reduce insurance denials, produce more accurate bills, and ensure that VA receives reimbursement for services provided.

To assist in improving medical documentation, which we reported as a continuing operational issue, VA mandated physician use of the Computerized Patient Record System in December 2001 and reinforced its use through a VHA Directive in May 2003. The coders use the electronic medical records to determine what treatment each patient received and to document the diagnostic codes. In addition, the medical centers have been educating the physicians about the importance of completing the records.

To reduce billing backlogs, VHA entered into an agreement with four vendors to code and assist with backlogs. The Washington, D.C. medical center hired a contractor to handle a backlog of 15,000 encounters.<sup>9</sup> The contractor has certified staff for coding and billing and must meet 12 performance measures. The revenue officer told us that the backlog was eliminated in May 2004. In addition, in December 2003, VHA was given authority by the Office of Personnel Management to directly hire credentialed coders at industry-compatible salaries.

In fiscal year 2003, VHA's Chief Business Office implemented industry-based performance metrics and reporting capabilities to identify and compare overall VA revenue program performance. Metrics were introduced to measure collections, days to bill, gross days revenue outstanding, and accounts receivable over 90 days. For both network and medical center directors, the metrics and associated performance targets were incorporated into annual performance contracts effective fiscal year 2003. VHA officials attribute much of the decrease in days to bill and increased billings and collections to these performance measures. For example, VA reported that nationally the average days to bill insurance companies for the first half of fiscal year 2004 was about 74 days, which is an improvement from their fiscal year 2000 average days to bill of 117 days. However, VHA's average days to bill for that period exceeded the

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<sup>9</sup>An encounter is defined as a single medical treatment.

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performance goals of 50 days and 47 days for the first and second quarters of fiscal year 2004, respectively. The industry standard is 10 days.<sup>10</sup>

In addition to actions already taken, VA's Plan has several other initiatives under way for improving billing times and increasing collections. For example, the Patient Financial Services System is designed to integrate the health care billing and accounts receivable software systems to replace VA's current legacy system. The system is intended to increase staff efficiency through a streamlined, standardized, re-engineered process; create more accurate bills; and shorten bill lag times through automation. VA officials believe that this initiative, when implemented, will reduce manual intervention noted earlier in our report as a reason for delayed billings. However, implementation is behind schedule.

Another effort under way, the electronic Medicare Remittance Advice project, helps to address obtaining allowable payments from secondary insurance companies, rather than accepting partial payments that are significantly lower than billed amounts as full payment. This project involves the electronic submission of claims to a fiscal intermediary<sup>11</sup> to receive remittance advice on how Medicare would have paid the claim if it were legally bound to pay VA for care. The remittance advice, which will be attached to VA health care claims, will enable secondary insurance companies to determine the correct amount to reimburse VA. Further, VA believes it will be able to more accurately reflect the amount of its outstanding receivables and be in a strengthened position to follow up on partial payments, which it deems incorrect. The completion date for this project was November 2003 but has been delayed due to software issues. VA officials told us they plan to roll out the new system beginning in August 2004.

Although the Plan provides another step forward in potentially improving operations and increasing collections, it is still in progress and many of the actions are not scheduled for implementation until at least fiscal year 2005.

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<sup>10</sup>As we noted in our 2003 report, VA's performance does not compare favorably to some industry benchmarks, such as the number of days required to bill. However comparisons between VA and the private sector should take into account how VA's processes differ from those in the private sector. For instance, VA has the additional step of determining whether the care is service-connected, and VA bills for both facility and physician charges. By comparison, private sector hospitals may only bill for facility charges.

<sup>11</sup>A private company that contracts with Medicare to pay Medicare Part A and some Part B bills.

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Therefore, it is too early to determine whether the Plan will successfully address operational problems and increase collections when fully implemented.

In closing, Mr. Chairman, we believe strengthening internal controls such as clarifying billing and claims follow-up procedures and consistently implementing policies and procedures could help reduce billing times and increase collections. Even assuming that VA's Revenue Action Plan works as contemplated, these additional controls are needed to maximize VA revenues to the fullest extent for enhancing its medical care budget.

Our report, which is being released at this hearing, makes five recommendations to strengthen internal controls that will facilitate more timely billings and improve collection operations.

This concludes my statement. I would be happy to answer any questions you or other members of the subcommittee may have.

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## Contacts and Acknowledgments

For information about this statement, please contact McCoy Williams, Director, Financial Management and Assurance, at (202) 512-6906, or Alana Stanfield, Assistant Director, at (202) 512-3197. You may also reach them by e-mail at [williamsm1@gao.gov](mailto:williamsm1@gao.gov) or [stanfielda@gao.gov](mailto:stanfielda@gao.gov). Individuals who made key contributions to this testimony include Lisa Crye, Jeff Isaacs, and Sharon Loftin.

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