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."
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> "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."
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> "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.