FOURTH HEARING ON VA'S THIRD PARTY COLLECTIONS

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BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

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July 21, 2004

FOURTH HEARING ON VA'S THIRD PARTY COLLECTIONS

WEDNESDAY, JULY 21, 2004

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

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Bilirakis, Boozman, Hooley, and Filner.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. Good morning. The Subcommittee on Oversight and Investigations of the Committee on Veterans' Affairs will come to order. Today's hearing is the fourth oversight hearing held by the subcommittee on the VA's third party collections program.

The good news is that collections have risen from $690 million in fiscal year 2002 to $1.489 billion in fiscal year 2003. On the flip side, there was $1 billion, though, in unbilled care in fiscal year 2002, and $516 million in fiscal year 2003, and those are just estimates. The question is, how has this been allowed to happen? Even though the amount was reduced by half, the better question is, how much has been collected, how much is even in the calculations to have been collected?

Our last hearing on this issue was 14 months ago. I think it's important that we take a look at where we are today in terms of what the VA told us would be accomplished and what has actually been completed.

At our last hearing, former Deputy Secretary Mackay talked about the need to use "industry best" performance practices to ensure reliable registration, insurance identification and verification, and pre-authorization processes. These "best practices" were incorporated in the 2001 Revenue Cycle Improvement Plan. Today we hope to learn when the VA anticipates completion of this plan, which was designed to improve core business processes. To date, 17 of the 24 proposed initiatives have been completed. What is the status of the most difficult last seven initiatives?

The other major program that was touted by the VA is the Patient Financial Services System demonstration. The PFSS pilot project was originally scheduled for implementation in late fall of 2003. The pilot is designed to test PFSS in order to demonstrate how an integration of commercial patient management and finan-

cial software programs is supposed to significantly improve VA's third party collections by capturing and consolidating inpatient and outpatient billing information. Unisys Corporation was selected by the VA to implement the pilot project.

Today we will receive an update on the PFSS pilot project. In particular, we will examine why the November 2003 projected implementation date was missed and why it was necessary to rebaseline the entire project in June 2004 with new milestone dates.

Now please don't get me wrong. I do not believe we should rush through the process. I do want to get it right, because I do concur with Unisys that whatever model we have is one for which there can be leverage. What we don't know is if this is the correct model.

At the same time, I don't think sound project management practices were used by the VA in the initial stages of this project. This appears to be a common reason for repeated failures of almost every major IT initiative in the VA.

Frankly, it concerns me that the VA did not have a business plan prior to start up of the project, and that an analysis of the VA's current business process was not accomplished until June of 2004.

It appears the poor management practices that led to the virtual meltdown of CoreFLS, a major IT initiative at Bay Pines, FL, could also plague the PFSS project, and for that, we will continue our oversight.

As we know from past hearings, there are several problems that have been repeatedly identified in the last 8 years that contributed to the VA's poor performance in collections. They include missed billing opportunities, huge billing backlogs, undocumented or inadequate follow-up in pursuit of accounts receivable, and the whole coding issue. The GAO and the VAIG will share their findings with us on what the VA has done improve these areas.

Another area that is an integral part of the collections process is how much it costs to collect. The GAO will provide us with an analysis of why the VA still does not know how to calculate the cost of its collections efforts.

I look forward to this hearing today and all of our witnesses. At this time, I'll yield to the Ranking Member for any comments she may have. Ms. Hooley, you are now recognized.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair. At the core of today's hearing, we have two issues. The first is the collections of third party payments to offset veterans health care. These payments are possible because a veteran is covered partly on a private health insurance policy.

The second issue revolves around the Patient Financial Service System, a system designed to track and manage, among other things, veterans' health care cost and the recovery of cost from third parties. Both the recovery cost and the fielding of information management systems have a long and sometimes rocky history at the VA. I note a degree of progress on each front, but there's a lot more work to be done.

Third party recovery is part of the Medical Care Collections Fund. The MCCF recoups revenues comprising a meaningful part

of veterans' health care costs. This subcommittee has consistently advocated a robust MCCF program at VA.

The MCCF is a revenue cycle consisting of four functions, each function containing some two to five activities. VA has pursued methods of process improvement for each subpart but has yet to define what the universe is of possible recoveries. To determine the extent of the universe, it would be necessary to determine 100 percent of third party coverage by veterans seeking treatment for non-service-connected problems and similarly have 100 percent accuracy for each of the remaining parts of the revenue cycle.

Once this universe of potential MCCF recoveries is known, the collection performance can be determined. When the universe of recovery is quantified, other items, such as the cost to collect once it is standardized, clinical documentation, coding accuracy, billing time and billing follow-up activities, will then have measurable performance attributes. Absent this key item, solutions and recommendations for improvements are couched only in terms of process improvements and work outputs. They will not shine a bright light on overall program effectiveness.

The MCCP may be aided through an information technology-based support system called the Patient Financial Services System (PFSS). As you know, Mr. Chair, VA has had some difficulty successfully fielding major information technology systems in the last decade. In the past, VA has missed the mark on price, performance and timeliness regarding IT system development. It was often difficult to determine who at VA was accountable for achievement of any given system requirement. There were miscues between VA managers and contractors that contributed to delays and problems.

I am heartened at the detail of the rebaselined milestones recently provided by VA regarding this system. Many milestones are now provided with the name of the individual accountable for accomplishment of that item. The original milestones were not met for a variety of reasons. There are many promising indications that the PFSS will not follow in the unsteady footsteps of other VA IT systems that have preceded it.

I must note that many IT projects, not only at VA, but at other organizations, have looked promising in the early stages. I also note that the testimony provided today by the VA witnesses and by the contractor seem to reflect diverging paradigms for developing the system. The VA testimony on page 2 speaks to the automation of existing processes. Here the sense is that the automation will fit existing VA MCCF processes.

The contractor's testimony outlines a different approach. It speaks to a technical solution requiring a significant business transformation process to align the VA revenue cycle organizations and business process with a target future state supported by a commercial off-the-shelf system. Here the sense is that VA MCCF processes will adapt to meet the automation. Hopefully, the various touch points will bring these positions closer together.

Finally, I look forward to learning about the opportunities that may exist for the last step in the VA MCCF revenue cycle—the appeals process. There may be an as-of-yet untapped potential regarding revenue recoveries using eAppeals-EDS methodology.

There are many promising indications that the PFSS will not follow in the unsteady footsteps of other VA IT systems that have preceded it. I must note that many IT projects not only at VA but at other organizations have looked promising in the early stages.

Finally, I look forward to learning about the opportunities that may exist for the last step in the VA revenue cycle, the appeals process, and again there may be as-of-yet untapped potential regarding revenue recoveries using the eAppeals-EDS methodology.

Mr. Chairman, I yield back the balance of my time.

Mr. BUYER. Thank you. Mr. Filner, an opening statement?

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Just briefly, thank you for holding this hearing, and of course we want to make sure that the VA gets all the third party payments that it is due. We know about the increasing needs, and we need to make sure that we do get every dollar.

As the chairman pointed out, there has been improvement made in these third party collections. The figures you used, Mr. Chairman, were different than the staff gave us in a briefing, so maybe we can——

Mr. BUYER. Well, it's a moving target.

Mr. FILNER. So let's get some agreement on those. But clearly, progress has been made. We don't want to stop here, of course. There will be testimony, I understand, in the second panel about some success that the Florida operation has had using a private company, eAppeals. I am interested in hearing about their methods to collect money from cases that had been previously been labeled as dead ones.

The appeals process is very important, not only to retrieve insurance payments, but to put the pressure on insurance companies, put them on notice that the VA will no longer be accepting a small percentage of the full payment, and to let them know that a payment of 5 or 10 percent of the total amount will not be acceptable.

So I look forward to hearing the testimony. I appreciate the opportunity that you have given us, Mr. Chairman.

Mr. BUYER. Will the first panel please come forward. We have Mr. Michael Staley, the Assistant Inspector General for Auditing, Department of Veterans Affairs; Ms. Cynthia Bascetta, Director of Health Care, Veterans' Health and Benefits Issues, United States Government Accountability Office; Mr. McCoy Williams, the Director of Financial Management and Assurance Team, the United States Government Accountability Office.

Mr. Williams, you are now recognized for 5 minutes.

STATEMENTS OF McCOY WILLIAMS, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE TEAM, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY MICHAEL L. STALEY, ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF VETERANS AFFAIRS, WILLIAM H. WITHROW, DIRECTOR, KANSAS CITY AUDIT OPERATIONS, DEPARTMENT OF VETERANS AFFAIRS, AND CYNTHIA A. BASCETTA, DIRECTOR, HEALTH CARE VETERANS' HEALTH AND BENEFITS ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

STATEMENT OF McCOY WILLIAMS

Mr. WILLIAMS. Thank you, Mr. Chairman. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss internal controls over VHA's third party billings and collections.

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 VHA's ability to maximize its third party collections to supplement its medical care appropriation.

In light of these concerns, you asked us to review internal control activities over third party billings and collections at selected VA medical centers. Our report on this issue is being released today at this hearing.

You also asked that we review internal controls at selected VA medical centers over personal property, drugs returned for credit, and part-time physician time and attendance. The report covering these three areas of operations will also be issued today.

My testimony today will focus on certain weaknesses in VA's billings and collections processes. I will also cover some of the initiatives VA has underway to address its operational problems.

We focused our work on billing transactions from the first quarter of fiscal year 2004 at the Cincinnati, OH, Tampa, FL, and Washington, DC medical centers. Mr. Chairman, we found that medical centers could further improve billing timeliness by continuing to address operational problems that slow down the process. These include delays in verifying and updating patient insurance information, incomplete or inaccurate documentation of patient care by medical staff, manual intervention required in the billing process, and workload levels at the three medical centers we visited.

Mr. Chairman, we also 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. Both VA's handbook and its accounts receivable third party guidebook provide procedures for following up on unpaid reimbursable insurance cases including first and second follow-up calls.

For the 90 cases, we tested, we found that follow-up calls were not made in a timely manner, nor were they documented appropriately with the contractor's name, title, telephone number and expected follow-up date. Delays in making second follow-up calls increased the risk that payments will not be collected.

Mr. Chairman, VA does have initiatives underway to address its operational problems, and has reported that its efforts have increased collections from $540 million to $804 million between fiscal years 2001 and 2003. 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.

Mr. Chairman, we believe this plan is a step forward in potentially improving operations and increasing collections, but it is still in progress, and many of the actions are not scheduled for implementation until at least fiscal year 2005. 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, I would like to emphasize that strengthening internal controls by clarifying and consistently implementing billing and claims follow-up procedures could help reduce billing times and increase collections. Our report makes five recommendations we believe will facilitate more timely billings and improve VA's collection operations.

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

Thank you.

[The prepared statement of Mr. Williams appears on p. 42.]

Mr. BUYER. Thank you. Ms. Bascetta, you are recognized for 5 minutes.

STATEMENT OF CYNTHIA A. BASCETTA

Ms. BASCETTA. Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss our latest report on VA's Medical Care Collection Fund. Congress authorized VA to collect copayments from veterans for treatment of their nonservice-connected disabilities as well as to collect third party payments from health insurers to help cover the costs of care for veterans with private health insurance.

Your interest in this topic has been longstanding, and we have reported to this Subcommittee many times on VA's progress. As you know, in fiscal year 2003, recoveries increased substantially, and VA collected nearly $700 million in copays and $800 million in third party payments. But during your hearing last May, questions were raised about the accuracy of VA's reported costs to collect.

In the report that we are releasing today, we found that VA's reported cost to collect copayments and third party payments from health insurers are inaccurate. We were unable to determine if the reported costs are over or understated because of inconsistent accounting, although we found several examples of omitted costs in our review.

Although VA has developed a comprehensive data management system to support its bill-processing function, it has not provided guidance to its Chief Business Office and its networks on how to account for costs associated with collecting payments. This contributed to inconsistent allocation of costs.

The chart on the highlights page of our report illustrates the variability we found across the networks. You can see, for example,

that for the insurance identification activity, five networks included all these costs while nine included part of the costs and seven didn't include these costs at all.

Our interviews with experts in the private sector led us to conclude that business practices within the same organization, including VA, should be standardized. We also learned that different health care organizations may use different judgment in deciding which variables to include in accounting for their costs to collect. For example, while most organizations would typically include activities like bill creation, other activities such as coding are often handled differently from one organization to another.

In our review we also noted that both the Chief Business Office and the networks excluded some significant collection costs. For instance, costs were not included for staff at the Health Eligibility Center, who spend part of their time determining veterans' copayment status. Similarly, we found significant omissions of contract costs in two networks, totaling more than a million dollars—$470,000 for collecting third party payments, $104,000 for insurance verification, $100,000 for software to review the technical accuracy of claims, and $425,000 to license the use of other necessary software.

Another network did not include $635,000 it incurred for a call center to assist veterans with questions about bills they receive and to arrange payment plans.

In our report, we recommend that VA provide guidance for standardizing and consistently applying across VA the accounting of costs associated with collections, and VA concurred with this recommendation.

We also reviewed VA's practice of using collections from third party insurers to pay for veterans' copayments. We found this practice increases VA's administrative expenses. Seventeen of the 21 network officials we interviewed told us about the opportunity costs associated with implementing this practice. For example, considerable staff time, up to 11 full time equivalent staff in one network, are needed to implement this practice. Moreover, paying veterans' copayments with third party payments from insurers reduces overall collections.

In our review, we did not find any locations that track the volume of uncollected copayments and their relative dollar value. Therefore, neither we nor VA has an estimate of how much additional revenue could have been collected to further supplement the medical care appropriation.

Mr. Chairman, neither the law nor the legislative history is clear about the use of third party collections for this purpose. VA has taken the position that payments from third party insurers should be used to pay veterans' copayments. We suggest that the Congress may want to consider clarifying the cost recovery provisions in the law.

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

[The prepared statement of U.S. Government Accountability Office appears on p. 42.]

Mr. BUYER. Thank you. Mr. Staley, you are recognized for 5 minutes.

STATEMENT OF MICHAEL L. STALEY

Mr. STALEY. Thank you, Mr. Chairman. Third party collections. During the past several years, our office has reviewed selected Medical Care Collection Program issues and identified opportunities to enhance recoveries and improve processes. In September 2001, the Inspector General testified before you on the Department's problems with processing bills and following up on accounts receivable, which has hindered VA's collections efforts.

In February 2002, we issued an audit report on the Department's collection activities. We found that the Department could increase its fiscal year 2000 collections by improving its processes and by clearing the backlog of unissued bills, which at the time totaled about $1 billion. We reported that efforts to aggressively pursue collections and to improve processes could increase revenues by about $500 million.

Also in February 2002, we issued a report on problems concerning the accuracy of coding bills sent to insurers for collection. The review was conducted at 15 VA medical centers and found that about 50 percent of the outpatient visits and billings we reviewed contained coding errors.

As projected, the Department has increased their collections. In fiscal year 2003, third party collections totaled over $800 million.

Although collections increased in fiscal year 2003, our reviews and GAO's recent audits continue to identify opportunities to increase revenues and improve controls. Our recent Combined Assessment Program, which provides cyclic coverage of VA facilities nationwide, are continuing to show that the Department could improve processing and collections in such areas as unbilled and delinquent accounts receivable, missed billing opportunities and accurately coding for medical services.

For example, in April 2004, we published work conducted at one medical center where we identified almost 26,000 unprocessed claims for episodes of care. We estimated that VA employees could have collected about $542,000 from third party payers by processing these claims.

Currently, the Department is in the process of implementing a Revenue Action Plan that includes 16 actions designed to increase collections and standardizes processes. This project to implement some of this is the Patient Financial Services System, as was mentioned today.

As of June 2004, Department status reports showed that the analysis phase of this project was near completion and they would shortly be entering into the design phase.

Allegations made by the American Association of Retired Persons concerning improper or fraudulent billings emphasize the importance of the Department implementing planned objectives and improving collection practices.

We issued a report in December 2003. While we did not substantiate fraudulent activity, we did substantiate coding errors. The Department is working with the AARP representatives to resolve discrepancies, and we continue to monitor efforts until all issues are resolved.

In conclusion, the Department has increased collection revenues, but more needs to be done. This completes my statement, Mr.

Chairman. I would be pleased to answer any questions you and the subcommittee members may have today.

[The prepared statement of Mr. Staley appears on p. 58.]

Mr. BUYER. Thank you very much. Let me turn first to Mr. Williams, with the GAO. I've had an opportunity to read your report. On page 14 of the report, you begin to talk about the difficulty in the post-Medicare payment information. If we have so many of our veterans who are Medicare eligible and we have difficulty obtaining information so that we can actually send a proper bill to a secondary payer, can you tell us what you're doing to figure this out and make it right?

Mr. WILLIAMS. Well, one of the things that we believe will assist in addressing this problem would be the implementation of the Medicare Remittance Advice system. Once this system is implemented, information will be provided in which VA as well as the third party insurance companies will know the amount that Medicare would have paid. And once that amount is known, then there should be no dispute between VA and the third party insurance companies as to what they should be paying.

At the current time, VA does not know what they should be paying because they do not have the information as far as what Medicare would have paid. But this new system would provide that information, and that should increase the billings as well as the amount of revenue that VA is able to collect.

Mr. BUYER. And when will this system be implemented?

Mr. WILLIAMS. The agency is currently in the process of testing this system and rolling it out now. We believe August is the date that we were told that they're expecting to have it out.

Mr. BUYER. All right. Help me out here.

Mr. WILLIAMS. Okay.

Mr. BUYER. You've been doing this for 7 years.

Mr. WILLIAMS. Yes.

Mr. BUYER. It's been one huge problem, right?

Mr. WILLIAMS. That's correct. That is correct.

Mr. BUYER. And right now the VA uses the spaghetti approach.

Mr. WILLIAMS. That's correct.

Mr. BUYER. Throw it against the wall, and whatever sticks, that's what you collect, and you think that's okay. So obviously by your report, you don't like that either, and you're giving some recommendations to them. What really kind of bothers me here, and I can sort of read from this, we lump it all on the secondary payer. You figure it out. We should be able to develop and design a matrix that has simultaneous, linear coefficiencies with a proper arrays and disciplines that affect processes and human nature. Do you agree with that?

Mr. WILLIAMS. I agree. I agree.

Mr. BUYER. Now, let me ask this. Is that what you foresee the VA is going to design and implement to affect the Medicare eligibles that are in the VA system?

Mr. WILLIAMS. If implemented as planned, that information would be available, I guess you could call this a reengineering of the process from the standpoint of they would have the information at the beginning so that they would know this is how much VA would have received if Medicare paid.

Mr. BUYER. Does VA believe that they can do this in-house?

Mr. WILLIAMS. I'm not for sure. I can get a response——

Mr. BUYER. I can tell you about the VA. They're going to by out sourcing it.

Mr. WILLIAMS. Yes. I'm not for sure if they believe they can do it in-house or not. But they're under way in implementing this system, and as I said, in some of the other areas, it's too early to tell how successful——

Mr. BUYER. Do you have any idea how much has been left on the table over the last 7 years because of not being able to do this?

Mr. WILLIAMS. We do not have an estimate. It is difficult to tell when you've hit that diminishing return or when you've put procedures in place where it would cost you one dollar and one cent to collect an additional dollar.

Mr. BUYER. Well, it would be pretty easy to try to figure it out just by using sloppy math, right? By taking that total population, and if you're only collecting pennies on the dollar——

Mr. WILLIAMS. That's correct.

Mr. BUYER (continuing). It's hundreds of millions. Would you agree?

Mr. WILLIAMS. That could be. There's the potential for millions of dollars to be collected if some of the control weaknesses that we've identified, some of the systems that the agency plans to implement or it is in the process of testing or rolling out are put in place. If you get those procedures in place, and address those control weaknesses, we believe that there are probably millions of dollars more that could be collected for veterans' benefits to be used for veterans care.

Mr. BUYER. Thank you, Mr. Williams.

Ms. Bascetta, do you have any comments on my questions or statements?

Ms. BASCETTA. I would just add with regard to the Medicare Remittance Advice that we first pointed out the importance of this in 1997, and as you know, there hasn't been much progress, but there have been 7 years of assurances that it was right around the corner.

And with regard to your concern about how much is still on the table, we, to use your phrase, we undertook some sloppy math of our own, and I would agree with you that potentially hundreds of millions of dollars are on the table.

Mr. BUYER. Mr. Staley?

Mr. STALEY. The project will be predicated on the Department's success in being able to electronically submit claims to Medicare intermediaries, which would enable them to receive advice. The success of the project will depend on whether the Department can successfully link to these intermediaries to find out whether to pay the client, or to find out what they need to do to pay the client.

If there are any functionality problems, the Department will pretty much have to deal with it. We have no idea as to what the overall potential recovery is, but as was just said by GAO, it is substantial.

Mr. BUYER. Thank you. Ms. Hooley, you are now recognized.

Ms. HOOLEY. Thank you, Mr. Chair. Mr. Williams, on page 8 of your testimony you cite the VA handbook to describe the VA proc-

ess for following up on overdue bills, and you state: However, if there is a considerable difference between the amount collected and the amount billed, the handbook directs staff to take a variety of actions to go after additional revenue.

Do you know how VA describes the term "considerable," if there's a considerable difference?

Mr. WILLIAMS. That was one of the issues or concerns that we had. That's a definition that can be very broad in interpretation. You would probably be much better off if there was some specific dollar range or something included in that, because that can be interpreted differently by——

Ms. HOOLEY. A dollar range, a percent range, something?

Mr. WILLIAMS. Exactly. Exactly.

Ms. HOOLEY. Ms. Bascetta, everyone seems to have dissected the MCCF process into a number of functions and activities, all for the purpose of increasing revenues. To some extent, recently this is achieving a more positive result than in other years. However, how can any MCCF result be characterized in terms of performance if the maximum possible result is not known?

Ms. BASCETTA. Well, that is the bottom line. And although I didn't address it in my statement this year, last year in our testimony, our bottom line message was that VA lacks a reliable estimate of the uncollected dollars, and because of that it does not have a basis to assess its systemwide operational effectiveness. And it won't until it can estimate the universe of potential collections.

Ms. HOOLEY. Do we know how many veterans are really covered by a policy?

Ms. BASCETTA. I believe the VA has an estimate. I don't know what it is.

Ms. HOOLEY. Is it possible to document and code and bill for 100 percent of permissible actions? Is that possible?

Ms. BASCETTA. I'm not sure I understand your question.

Ms. HOOLEY. Well, I mean, can you actually ever bill 100 percent, to document that and code that of permissible actions? Can you get to 100 percent?

Ms. BASCETTA. Probably not practically. I don't know what the correct percentage might be.

Ms. HOOLEY. In my opening statement I talked about what's the universe. Is there—can we—how do we ever get to the results, the results we want if we can't define what our universe is out there?

Ms. BASCETTA. Well, that's why we suggested to VA last year that they develop exactly that kind of estimate. And it's a function of many things. It's not necessarily simple to derive. It's a function of how many veterans have non-service connected disabilities first, because that's the treatment that's potentially recoverable, and then from that point, they would need to estimate how many have treatment, treatment for different kinds of conditions and the various copays, you know, the copays for drugs versus specialty care versus inpatient care are all different. And then to the extent that they have insurance, you know, what is the coverage that they have.

They would not be able to recover fully, for example, if a veteran had a supplemental policy that had first dollar coverage. So there are a lot of variables that go into the estimate. We don't think it's

impossible by any stretch, and it's certainly necessary to better understand that.

Mr. BUYER. Dr. Boozman?

Mr. BOOZMAN. Yes. In your testimony, Ms. Bascetta, you said that we should look at clarifying the recovery provisions in the law. How would you specifically—what language are you talking about specifically?

Ms. BASCETTA. Well, the law is unclear as to whether or not VA can or should apply third party collections to pay for veterans' copayments for those veterans who have copayments by virtue of having a higher income. Because the law is silent on this matter, VA's general counsel has written an opinion quite a while ago that says that VA should use the third party collections to pay the copays.

And of course this is the Congress' call. Our concern is that this significantly raises their administrative costs as well as reduces the total amount of collections because those copays that are paid by the third party insurance would have been recoverable.

Mr. BOOZMAN. There's many questions about how much we're leaving on the table, and I think that is a fair question. It does look like you could take, you know, one of the larger VISNs or whatever, and at least know, you know, go through the math like you're talking about, and then using industry average.

The VA is not the only one that is going through this. I mean, hospitals go through this, individual clinics. Some of them have excellent ability to seek out. The hospitals are much more efficient than they used to be because their revenues decrease so much. But I do think that's a fair question. I do think you can use the industry average very easily. I know it's not exactly the same, but you can get a ballpark figure. And like I say, I very much would like to have that answer fairly shortly.

Thank you. Go ahead, if you've got a—I mean, do you agree with that, that you could use industry averages?

Ms. BASCETTA. I think the VA is attempting to benchmark themselves against an industry average. I think the problem is that until they have consistency and an accurate measure of their cost to collect as well as this definition of the universe, there's no comparison to make. We have to get the numbers out of VA to make the comparison.

Mr. BOOZMAN. What's a reasonable time to get the numbers?

Ms. BASCETTA. Well, with regard to the consistency, that should be very quick. In fact, in January of this year, VA prepared an executive decision memo laying out how they would consistently allocate their costs. So that's just a matter of making a decision and applying it.

With regard to the estimate, that might take a little bit longer, but I would ask VA that question.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Mr. Filner, you are now recognized.

Mr. FILNER. If I may ask the GAO folks. The insurance companies who are not responding, is there some way to analyze whether there are certain companies or group of companies that are consistently not paying or underpaying? Do we have that information?

Ms. BASCETTA. I don't have that information. VA might. A few years ago we made a recommendation when they implemented reasonable charges that they monitor in local markets when insurers were paying under the reasonable charge rate, because we were aware that that might be happening fairly consistently in some markets.

So I would hope that they would be on top of that.

Ms. FILNER. Do you know, if there's a chronic underpayer, what happens in that case, and do they go after him?

Ms. BASCETTA. I don't have that information.

Mr. FILNER. I think there's an underpaying gold mine there that we ought to be thinking about how to tap. And I think other panels will also touch on that.

Ms. BASCETTA. If I might add, the other important part of underpayment is knowing the reason. If they're underpaying because they think they can get away with it, that's one thing. But if they're underpaying because they don't have a bill that, you know, withstands scrutiny or is up to industry standards that they might get from a private hospital or another provider, then there's some responsibility for VA to take action to improve that.

Mr. FILNER. We're talking about insurance companies, so I'm sure the first one has to be true. (Laughter.)

Mr. BUYER. Mr. Filner, would you yield?

Mr. FILNER. Yes.

Mr. BUYER. A few years ago we tried to take on the issue and we haven't had any success, and that deals with the HMOs. They consider the VA out of their network, and therefore they don't get that reimbursement. I just wanted to add that in, because of your question.

Mr. FILNER. I think they'll get into that on other panels, but that's an important thing to consider. Thank you.

Mr. BUYER. Mr. Bilirakis, you're now recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Mr. Chairman, first, I wanted to welcome some of the good people who have come up here from the Tampa Bay area.

[Mr. Bilirakis recognized constituents from his district.]

Mr. BILIRAKIS. And I say that, Mr. Chairman, because I just received word that our Energy and Commerce Committee chairman called an emergency meeting for subcommittee chairs at 11 o'clock, and I'm going to have to run to that. It's some sort of structuring thing. I don't know what the heck it is.

But having said that, Mr. Chairman, I had a couple of questions that we may not be able to get answered in this period of time. But who should I ask this question? Ms. Bascetta, as I understand it, the money that is collected, the third party money that is collected, now goes to the VISN. Is that correct?

Ms. BASCETTA. I think it goes to the medical center.

Mr. BILIRAKIS. Well, if it goes to the medical center, frankly, that's the way I think it ought to go. But I'm not sure. Do we know, Mr. Chairman? Does the money now go to the medical center?

Ms. BASCETTA. I see VA nodding behind me that it——

Mr. BILIRAKIS. It goes to the medical center.

Ms. BASCETTA. Yes.

Mr. BILIRAKIS. So the incentive is already there if it goes to the medical center for them to do a better job collecting?

Ms. BASCETTA. That's exactly correct.

Mr. BILIRAKIS. I think the conclusion here is that that incentive apparently is not enough. You know, the VA I guess sort of asked for this authority back in the late 1990s. The history behind this, and I hope I'm not misstating it, was when we talked about third party collections, the veterans organizations got awfully aggravated with it all because they said that's not right. These are veterans, and it should be taxpayers' dollars taking care of them and whatnot, whatever their reasons were. But finally everybody relented and we put it into effect back in, what, 1997. And the collections went to the Treasury, and then the feeling was, well, since it went to the Treasury, there's no incentive, and now it goes to the VA medical center. And I think if it goes to the center that has taken the time and trouble to collect the funds, that's the best incentive they could possibly have.

So it's just free money there. I've been told that if a federal employee, if a federal employee who is also a veteran receives care at a VA medical facility, the VA cannot collect from his third party insurer even though both the employee and the federal government have paid their monthly premiums. Is that true? Does anybody know?

Ms. BASCETTA. I don't know the answer to that question. I know that in our 1997 report, we did look at FEHBP. I could go back and try to answer that for the record.

Mr. BILIRAKIS. Is there any good reason why that could be true or should be true? No? All right. They say you should not ask a question unless you have the answer, and I don't know what the answer is.

Well, I'm actually submitting the question to the—am I submitting the question to you, Mr. Williams? I guess I'm really not. It would have be directed to the VA.

Ms. BASCETTA. You can send them to GAO and they'll figure it out.

Mr. BUYER. Mr. Bilirakis, if there's no objection, we'll have written questions you can submit to the VA.

Mr. BILIRAKIS. Okay. I am concerned about that, because it really goes to the bottom line, and that is, you know, why, for crying out loud? People are paying their premiums. The insurance companies are benefitting. If you don't get out there and try to collect from them for care that was not—didn't come out of the insured pockets. And so why in the world are we just leaving that money there? It's just free money.

It's unbelievable to me that we're having these kind of problems. And I know that the volume of collections are increasing on a gradual basis. But, I mean, how long does it take, for crying out loud, before we really get to the point where we're collecting practically all of it? And I know there's another panel, and I might be able to get back here for that and I might not. But, you know, that's really the question we have here. I think it's just ridiculous that we keep talking about this and nothing seems to be happening, you know, better things are not taking place.

All right, Mr. Chairman. In the interest of time, I'll just yield back.

Mr. BUYER. That's all right, Mr. Bilirakis. Every time we do these hearings, I'm filled with the very same emotions. It's why we went and met with Mr. Walsh, Chairman on the Appropriations and decided to do a pilot project, and now I'm not the happiest man in the world with regard to where the pilot even is.

Ms. Bascetta, I am going to ask you if you can take on the task of monitoring the contract between VA and Unisys and to make sure that the milestones which they've set are achieved. Can you do that?

Ms. BASCETTA. Yes, we can. We also have colleagues in our IT (Information Technology) area in GAO, and I would certainly work with them on that because feasibility of the technology is I think at the core of the matter.

Mr. BUYER. I think you've heard from some of the members here that when we think of the private sector and they're able to get their bill out within 5 days and the VA sets a benchmark that you need to get it done within 50 days, you go out and you look at three different facilities, and you find that Tampa is 73 days, Washington, DC is 69 and Cincinnati were at 44, respectively. That's pretty poor in my book.

Mr. WILLIAMS. Yes. Well, there's a couple of things that you have to take into consideration. I'll take my doctor, for example. One of the first things that I do when I walk in the doctor's office, I'm asked, do you have insurance? And they won't see me if I do not have insurance. There's a little different issue when you go to a VA hospital.

But I would still encourage the agency to work very hard to do everything that it can to get those numbers down.

Mr. BUYER. Why, at the VA, were they unable to assess when you went on the ground, aren't the VA facilities firmer with the veterans with regard to getting their insurance information?

Mr. WILLIAMS. Well, there are procedures in place to get that information, but what we've found in the medical centers that we visited was that there were still veterans that were reluctant to give that information. It was fear that their private insurance or the their third party insurance would go up.

So there were still some issues that needed to be addressed a little bit more aggressively and new techniques and other things that the agency should be doing to make sure that that information is provided in a more timely manner, because this is the first step in the process that could cause things to be delayed.

Mr. BUYER. Given we have our own eligibility and access for veterans into the VA, should Congress even consider—I'll just throw this on the table. I know this is for us, but—making their access conditional upon the information?

Mr. WILLIAMS. I think that that is something that the Congress should give consideration to.

Mr. BUYER. You know, if you're going to go see your doctor and you don't cooperate, you're not going to give payment nor your information, you're not going to get past the front door? Probably not.

Mr. WILLIAMS. That's correct.

Mr. BUYER. And to Mr. Bilirakis' question, you know, why wouldn't these medical treatment centers be a little more ambitious with regard to collections? You know, Congress, we're pretty kind, Mr. Bilirakis. Somebody sets a benchmark and compassion is measured by the dollar, and, boy, we'll just pump money into the system and the system doesn't have to work as hard.

It seems like when the dollar reduced or gets tight, it forces people to think anew, is just my thoughts, Michael. I did note in the GAO report that sort of reminded me of what OPM had done, the changes in the regulations permitting those medical centers to do some contracting, reduce the time, and they got the backlogs done with regard to coding.

Mr. WILLIAMS. That's correct.

Mr. BUYER. But you know what? If we don't have the docs doing what they're supposed to be doing——

Mr. WILLIAMS. That's correct.

Mr. BUYER. How do you know whether the coding is even correct?

Mr. WILLIAMS. That is correct.

Mr. BUYER. And we have a real problem on processes. I'm just having a conversation with you about some of my thoughts.

Mr. WILLIAMS. Well, one of the things that I would like to add about that is, as we state in the report, there's four components of that revenue cycle, and you need things to be working in each component, because if it's not, you will run the risk of a delay in the billing. And any delay in billings in any accounting book where you're looking at accounts receivable, the longer it takes you to get the money in, the lower the probability is that you will collect that money. And in this process that you're looking at, it could be stopped or slowed down at any point along the way if something is wrong and you run the risk of losing revenue.

Mr. BUYER. Tell me why there's a contract in Florida with eSolutions? eAppeals. I'm sorry. eAppeals. It seems as if the government doesn't do what it's supposed to do, then somebody steps in to figure it out and to fill that void. Why don't we design those systems whereby we can do those things, or we're going to have to move toward contracting? Just your sense by your report.

Mr. WILLIAMS. What I've found in looking at systems implementation is reengineering of processes is the first key component to being successful in implementing a new system. Implementing a new process require that you have the people that are first of all dedicated at the top in the overall control environment. We call it having the right tone at the top. That you've got commitment from top management, you've got commitment throughout the organization.

You then need to have people that are capable of actually carrying out that plan. So I think you've got to have that in place, and you've got to have sustainability, because a lot of these projects go beyond one year.

So in looking at that process, if part of it can be done by people in house and part of it can be done by contractors, you need to look at that mix and whatever works the best to allow you to optimize achieving that goal of getting the system in place and adding to

your revenue, that's what should be put on the table, that's what should be implemented.

Mr. BUYER. Well, what you just mentioned I believe is one of the core elements of PFSS. And I want to have a side conversation with you after the hearing.

Mr. BILIRAKIS. Would the chairman yield? Ms. Bascetta, would it not work if let's say a team were to go to the VA medical center by medical center?

In other words, rather than an edict from up on high to all of the groups regarding some of the changes that Mr. Williams has been talking about, et cetera, et cetera, that, you know, a team were to go into a particular medical center and really dig into the process, find out what the problems are, if there are coding errors and things of that nature, what is needed there, and sort of get it fixed so that those people would reach the optimal point of collections?

Because it goes to their direct benefit and it doesn't go to the VISN or to the Department, and then go on to another one and do the same thing there?

It may take a little bit of while, but at the same time, not all these things are coming from up high, and it doesn't look like they're really working. Yeah, there's 50 IG visits so far. What's that mean?

Well, all right. So whatever it is, I mean, wouldn't that work? I don't mean an IG going and checking and find what faults are and what—I'm talking about fixing it.

Ms. BASCETTA. You mean on the job?

Mr. BILIRAKIS. On the job fixing the darn thing, not just where the faults are, and, you know, why aren't you doing this, but fixing it, just getting it done.

Ms. BASCETTA. Right. Yes. I think it would. And we noted a number of years ago inconsistent processes in different places. And, you know, there might not be one perfect way to do it.

Mr. BILIRAKIS. Right. Right.

Ms. BASCETTA. It might be that there are——

Mr. BILIRAKIS. Exactly.

Ms. BASCETTA (continuing). A few models, or that they need to be locally tailored. But we would think that as you're saying, with the incentive at the location that's going to be able to take that money back to serve more veterans, that that assistance at that location would be ideal.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. WILLIAMS. May I add a point?

Mr. BUYER. Ms. Bascetta, part of the problem, though, is there is no standardization of the processes?

Ms. BASCETTA. Oh, yes.

Mr. BUYER. We can be locally tailored, correct?

Ms. BASCETTA. Yes.

Mr. BUYER. All right.

Ms. BASCETTA. Standardization of the process and standardization of the cost accounting, so that they know ultimately what their cost to collect is, correct.

Mr. BUYER. And we have some human nature problems, right?

Ms. BASCETTA. A few.

Mr. BUYER. Right. A few? Mr. Williams?

Mr. WILLIAMS. Yes. I would just add to that point that what you would basically do in a situation like that, you would need some senior leadership maybe from headquarters that would be looking across the spectrum and trying to identify what are some of the best practices at the various locations and the individual processes, and as you identify those best practices, then you try to have those best practices implemented throughout——

Mr. BILIRAKIS. Well, but again, you're talking about it coming from on high, Mr. Williams.

Mr. WILLIAMS. That's correct.

Mr. BILIRAKIS. And that should work, but it doesn't work, for whatever reasons. Diversity exists and whatnot. And that's why, I don't know, you tackle the darn thing, maybe sometimes you've got to do it in a practical real world way, and that is doing it individually. I apologize, Mr. Chairman.

Mr. BUYER. No, no.

Mr. BILIRAKIS. Thank you very much.

Mr. BUYER. Appreciate your contribution. Ms. Hooley, you are now recognized.

Ms. HOOLEY. Thank you, Mr. Chairman. Mr. Williams, let me ask you a question. When a person goes into a hospital, goes into a clinic, we all have, you know, every single one you go into, you sit down and you fill out all this paperwork. Is that uniform throughout the system, that paperwork they fill out that talks about what other insurance they have, you know, do they have other family insurance, does the spouse carry insurance? Is that uniform?

Mr. WILLIAMS. Yes. My understanding is that you're basically collecting the same type of information from all the veterans.

Ms. HOOLEY. And why don't we get—what happens so that we don't get what the third party insurance is?

Mr. WILLIAMS. Well, one of the things that we were told as we were doing our work is that one of the major problems is that some veterans are hesitant to provide that information for fear that providing that information would cause their private insurance to go up.

Ms. HOOLEY. How do we know they're hesitant? I mean, if it asks on the form, how do we know they even have that third party insurance if they don't put it down?

Mr. WILLIAMS. Right now they wouldn't. It's basically getting that information from the veteran.

Ms. HOOLEY. So you go in the office, you fill out a form, you take it back to somebody. Does that somebody they take it back to say do you have another, you know, I don't—this isn't filled in—do you have another insurance? Do they go through that? I mean, does that happen?

Mr. WILLIAMS. There is a review process that——

Ms. HOOLEY. Does that happen right at the first time?

Mr. WILLIAMS. At the first time?

Ms. HOOLEY. Well, the first time I go in.

Mr. WILLIAMS. Yes.

Ms. HOOLEY. You want to get all the accurate information you can get.

Mr. WILLIAMS. That's correct.

Ms. HOOLEY. And that's the time you want to question them about tell me why this isn't filled in.

Mr. WILLIAMS. Right.

Ms. HOOLEY. Do you have any other insurance through any other members of your family?

Mr. WILLIAMS. That's correct.

Ms. HOOLEY. Doesn't that need to happen, and does that happen?

Mr. WILLIAMS. That needs to happen, and you need to get that information right up front. One of the things that you need in that process is to make sure that the veteran is providing you with all of that information, that they do have insurance or that they do not——

Ms. HOOLEY. But doesn't that mean someone has to talk to them a little bit in this whole process?

Mr. WILLIAMS. That's right. You have to work with the patient, or the individual when they come into the hospital to try to gather as much of that information as you possibly can. One of the things that you need to look at in that process is if there are tools available in which the VA would be able to do an independent verification as to whether that individual has insurance or not.

One of the things that you would be concerned with is if there are some privacy laws or things along that line that would prevent you from being able to tap into a database or something along that line to identify that. You know, this veteran said that I do not have insurance, but if you tapped into that database, you would be able to identify that they do have insurance with Company A or B. But right now, the information is coming from the veteran.

Ms. HOOLEY. For any of you, what's the percentage of collection of bills that we get from, you know, other institutions? I mean, if you're a hospital system, what percentage do they collect of the money that's owed them, do you know?

Mr. WILLIAMS. I do not have that information.

Ms. HOOLEY. What percentage do we collect in the VA system of what's owed us? Do we know?

Ms. BASCETTA. We don't know.

Mr. WILLIAMS. We don't know.

Ms. HOOLEY. Okay. Then let me ask you another question. Mr. Staley, you said you talked about a billion dollars of unissued bills and if you were able to collect them, that would mean another $368 million, right?

Mr. STALEY. Correct.

Ms. HOOLEY. I know that some things are kept by Medicare, for example. But is that the only thing that would result in that difference of here's a billion dollars out here and we're only going to collect $368 million of that? How come there's that much difference? What are the other factors?

And should we be collecting more than that? If you had ultimate systems, what percentage should we be collecting?

Mr. STALEY. I could not readily answer that, ma'am. I'd have to research that a little bit more——

Ms. HOOLEY. Okay.

Mr. STALEY (continuing). And get back to you in writing.

Ms. HOOLEY. I would be—I would like that in writing. It would be very interesting for me to know what we do in comparison to other institutions and then what's realistically should be our expectation, knowing we're never going to get to 100 percent, knowing there's caps by Medicare, all of these other factors play into that. But what's our ultimate goal? What should it be? What do we—where do we want to be when we get through with this process?

Mr. STALEY. That's a good question.

Ms. HOOLEY. Thank you.

Mr. BUYER. You know, Ms. Hooley, you come from the private sector. I understand the purpose of your question. It's difficult to define success if you cannot define the universe.

Ms. HOOLEY. Right.

Mr. BUYER. We can't even define what the universe is. My God. There is no way any of us in this room would be stockholders of a corporation that could not define its universe nor its success. So bringing business principles and practices to the federal government should not be a radical idea or concept. So, Ms. Hooley, when you ask that question, that's an appropriate question to ask.

I guess it's the purpose of making sure that the PFSS is successful, that it gets the right resources to accomplish its goal. Now whether we then can have the oversight to see whether or not that's the proper model, and I'm also a little conflicted because I want to be a good listener through this hearing. I want to talk to all the principals, but should we also have not only the PFSS or what's happening in Ohio, do we just hold that to a medical center and perfect that system, while at the same time we bring in a competitor and we have them go do a comparable. We make sure that they're both properly resourced and financed so we know how to do it and then leverage it out?

Because we know that the frustrations that we have here about saying, well, we're just going to let the VA do it internally. They've had 7 years. And the taxpayer here is not being treated well. The VA is not being treated well, especially when it affects quality of care.

Well, I'll get off of my diatribe here. I'm just really challenged at the moment. Let me turn to the IG here for a second. Let's look at it from this position. Are those individuals who work for the VA, are they properly trained to ask the right questions, to receive the proper information on eligibility and entitlement status? Right at the very beginning.

Mr. STALEY. Training has been an issue in reviews that we've conducted. To the extent that training is an issue, I really couldn't comment on whether that's the principal factor. But inexperienced clerks, inexperienced coders have factored into some of the problems we've identified.

Mr. BUYER. Would you concur with that, Mr. Williams?

Mr. WILLIAMS. Yes. That is correct.

Mr. BUYER. So that was your experience at the three facilities which was the basis of your report?

Mr. WILLIAMS. That's correct.

Mr. BUYER. The present coding error rate is approximately 50 percent today?

Mr. STALEY. It was in 2002, Mr. Chairman.

Mr. BUYER. Do you know what it is today?

Mr. STALEY. I don't have that number. I do know from our combined assessment program reviews that the error rates we're finding are lower. I couldn't give you specifics. But they're still appreciable lower.

Mr. BUYER. Now I'm going to jump into Ms. Hooley's vein of thought of the private sector. It's easy for us to sit here and beat up on the insurance companies about reimbursements.

But if I'm sitting at an insurance carrier out there and I know that I'm getting claims from the VA and you've got 50 percent error rates in your coding, I'm not so anxious to pay till the VA gets their act together, if I were in the private sector.

So we sit here and we go, okay, you know what? I think it's pretty good to deal with the VA if I'm an insurance carrier out there, because they're not going to bill me until between 50 and 70 days. That's pretty cool. And then once they bill me, I'll ignore the first bill. They may or may not call me on the second bill. And jeez, if they don't call after the second and third, they never hardly ever call on the third. I'll drag it out. And they drag it out.

Ms. HOOLEY. And then they write it off.

Mr. BUYER. Yeah, then the VA writes it off. And what a crazy way to do business. I'm very exhausted. I'm going to hang in here, though, with this one, not only myself, but Ms. Hooley and the staff on both sides of the aisle here are very committed to the issue. And we're also very exhausted about of all the money we pour into IT systems. And if it were up to me, I would change how we do systems with the VA.

If I get this opportunity, we'll do that. We'll set the pace for other departments in this country. Power is money in this town. If you want to write a good IT system, give them money. Give the person that's in charge money and make all those in charge of the business come to them. And we'll get standardization pretty quickly. We'll get electronic billing pretty quickly. We'll get, you know, we won't have so many failed systems. We know who's in charge, who's got right oversight, you know.

Well. Ms. Hooley, do you have anything else?

Ms. HOOLEY. Not at this time. I have lots of questions, but it feels like Groundhog Day over and over again.

Mr. BUYER. Yeah. That's well put. I think we're marching. We're marching somewhere. No, we're getting there. This is hard. It's hard because, you know, Congress, we did this eligibility reform and dropped it right on the VA and never anticipated the access into the system at a rate in which it came, and it's been very hard for them.

We've got a culture of bureaucracy out there. As Ms. Bascetta agreed, there are a few of those human nature problems or concerns. Mr. Williams, in your report, you talk about medical centers out there saying if you just give me a couple more employees, right?

Mr. WILLIAMS. Yes, that's correct.

Mr. BUYER. So we could give them a few more employees to help on that, but it is the right processes? Is it the right systems?

Mr. WILLIAMS. That's right.

Mr. BUYER. And so that's why this committee, in coordination with the Appropriations Committee, working with the VA, is going to find out what the right processes are. Because we want to make sure we have the right processes with the right mix, and the right IT, and the right people, because this is a lot of money.

Mr. WILLIAMS. That is correct. I would just add that, when you start talking about bringing up these systems, there are a lot of things that you need to take into consideration. One of the first things that you need to do as an organization is to look at your process to see, do I need to reengineer this process? Am I doing it the way it really should be done?

Then you need to look at your requirements to see exactly what are the requirements in order to bring that system on board. You need to have the good people. You need to have good project managers in place to make sure that the project has a timeline as to what you're going to do, because we're talking about a project that has been going on for 7 years. You raise some concerns about project management for a project that's taken this long.

And you get all those things in place and you tackle it from a standpoint that is manageable and something that's not so big that you can't handle it in one piece. You might have to break it down into segments.

I think if you take all those factors into consideration and you go step by step, you have a chance of being successful. But as you pointed out, we do not have a lot of success stories in the federal government at this particular point in time in bringing up systems.

Mr. BUYER. Ms. Bascetta, I gave you some tasking, and so we don't have a repeat of some of the problems that we had with Tampa. That was the purpose of the tasking, but I just want to make sure that I'm tasking it to the right agency. Should this go to you or should this go to the VA IG, or is it better at the GAO? Let's have an open conversation here.

Ms. BASCETTA. In anticipation of this hearing, I have already had a conversation with my colleagues in the IT area, and they're prepared to begin this work. We like to work as a matrix organization because we have different skill sets and can bring different expertise to bear. So we would work with them from the health care team and possibly our colleagues in FMA as well.

Mr. WILLIAMS. We would work with them also, because there's a financial management flavor that's involved here.

Mr. BUYER. All right.

Mr. WILLIAMS. It would be a matrix assignment.

Mr. BUYER. Okay. I just need to know who is my go-to. Do you want it to be Ms. Bascetta, and then she'll work with both of you when necessary?

Ms. BASCETTA. Yes. And you can call me. Yes.

Mr. BUYER. All right. Is that all right with you, Ms. Hooley?

Ms. HOOLEY. That's perfectly fine with me. And I think just a reminder. One of the reasons that we're doing this is that money is limited. We want to make sure that veterans get the best health care and that by collecting some of this money, it gives us more money to take care of our veterans, and that's really what this is all about.

Ms. BASCETTA. That's correct. We, in fiscal 2003, just so we're all clear about——

Ms. HOOLEY. It's not here beating up on people or talking about—sometimes you don't have the right systems or the right people in the right area. But it is what do we need to maximize our dollars so that we have the money to take care of our veterans like we need to?

Mr. WILLIAMS. I would add to that, that this is also a component of internal controls in which you have oversight that helps increase accountability.

Mr. BUYER. All right.

Ms. BASCETTA. In fiscal 2003, the appropriation was $25.5 billion. The collections were $1.5 billion. That is a lot of money.

Mr. BUYER. Wait a minute. Say what you just said.

Ms. HOOLEY. Say that again.

Ms. BASCETTA. In 2003, the appropriation was $25.5 billion and they collected $1.5 billion. So relative to the pot of money that they have, it's very significant.

Mr. BUYER. Okay. Can I ask you this? I know you've got a lot of things on your plate. When we bring up the second panel, could you stay?

Mr. WILLIAMS. Yes.

Mr. BUYER. Is that all right?

Mr. WILLIAMS. Yes.

Mr. BUYER. In case something comes up. I don't know if it will or not, but to have you in the room would be very important.

Mr. WILLIAMS. Yes. Okay.

Mr. BUYER. Thank you very much. This first panel is now excused.

I'd now like to recognize the second panel. The Honorable Robert N. McFarland, the Assistant Secretary for the Office of Information and Technology, the Department of Veterans Affairs. Accompanying him is Mr. Ken Ruyle, the Chief Business Officer, Veterans Health Administration. We also have Mr. Ken Ray, a VISN 8 Chief Financial Officer. And we'd also recognize Mr. Edward C., and he goes by "Ted" Davies. He's the Managing Partner of Unisys Corporation.

Well, Secretary McFarland, we are pleased that you are here. I wasn't sure whether or not you were going to be able to make it, but I am very pleased you're here. Because as you heard, I'm going to make you a very powerful fellow, if it were up to me. You know, these business offices that come to you for that signature and that write-off. But if I give you the money, you've got the power.

And we talked about this several years ago, and the Admiral didn't think he could do that, and he had worked it out with the Secretary and dotted line authority. Dotted line authority in this town just doesn't seem to get it, you know. All those years I spent over there on the Armed Services Committee, what I've learned is power on power and whose got the money. So I just want to let you know. Hang around, all right?

Mr. MCFARLAND. I intend to, sir.

Mr. BUYER. All right. You are now recognized for 5 minutes.

STATEMENTS OF ROBERT N. McFARLAND, ASSISTANT SECRETARY FOR THE OFFICE OF INFORMATION AND TECHNOLOGY, DEPARTMENT OF VETERANS AFFAIRS; W. KENNETH RUYLE, CHIEF BUSINESS OFFICER, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY STEVE YOUNG, ASSOCIATE DIRECTOR, TAMPA VA MEDICAL CENTER; MARIETTA (MARTY) ZIMMERMAN, BUSINESS OFFICE SERVICES COORDINATOR, ORLANDO/TAMPA VA MEDICAL CENTER; LORI HANCOCK, CHIEF, MEDICAL CARE COLLECTIONS, TAMPA VA MEDICAL CENTER; CLYDE PARKIS, DIRECTOR, VISN 10, CLEVELAND VA MEDICAL CENTER; PATTY GHEEN, PFSS IMPLEMENTATION MANAGER, VISN 10, CLEVELAND VA MEDICAL CENTER; KEN RAY, VISN 8 CHIEF FINANCIAL OFFICER, BAY PINES, FL; ACCOMPANIED BY MANNY SALETA, CHIEF, FISCAL SERVICE, MIAMI VA MEDICAL CENTER; WILLIAM KIRSH, PRESIDENT AND CEO, eAPPEALS; EDWARD C. (TED) DAVIES, MANAGING PARTNER, FEDERAL CIVILIAN AGENCIES, UNISYS CORPORATION; ACCOMPANIED BY JOE MACIES, PARTNER, UNISYS CORPORATION

STATEMENT OF ROBERT N. McFARLAND

Mr. MCFARLAND. Thank you. Good morning, Mr. Chairman and members of the subcommittee. As Assistant Secretary for Information and Technology and VA's CIO, oversight of PFSS lies within my Department's responsibilities. As Acting Chief Business Officer, Mr. Ruyle is charged with the day-to-day operational responsibility for the project. He and his staff are intimately involved in the development and the implementation of PFSS and are diligently working to ensure that the project stays on track and that significant milestone dates are met.

Briefly, we expect that PFSS will create a comprehensive business solution for revenue improvement, utilizing a combination of commercial software and enhanced VA clinical applications.

PFSS is being developed to support both first party copayment and third party insurer billings, and it will improve service to veterans by helping to standardize information to be shared across VA.

We also expect that it will help to enhance the Department's revenue performance, the latter of which I understand has been of considerable concern to this committee over the past few months. It's our belief that with the eventual implementation of PFSS, efficiencies in revenue claims processing will be introduced.

To help us achieve that goal, I have since changed the management of the project from a matrix approach to one with a single point of accountability. In conjunction with my prior testimony last March, I want to reiterate that the Office of Information and Technology has laid the overall groundwork for such departmental projects by initiating a rigorous IT management process.

One element of that process is an active Enterprise Information Technology Board that has been implemented as a disciplined project management methodology. It is one that aggressively manages the agency's IT portfolio, including projects like PFSS. We intend to leverage the EITB and the project management process to ensure that there are well defined linkages among, one, the De-

partment's enterprise architecture; two, the IT portfolio; three, identified resources; and four, anticipated benefits from IT projects in development.

As CIO and chairman of the EITB, I intend to exercise my oversight responsibility accordingly and have every confidence that under Mr. Ruyle's direction, PFSS will continue on a steady track, will be fairly tested, and will ultimately successfully be implemented.

I thank the committee for the opportunity to appear and await your questions.

Mr. BUYER. Mr. Ruyle, will you testify?

Mr. RUYLE. Yes.

STATEMENT OF W. KENNETH RUYLE

Mr. RUYLE. Mr. Chairman and members of the Subcommittee, I am pleased to be here today to inform you of the continuing progress, challenges and future direction of the Department of Veterans Affairs revenue program and to update you on the current status of the implementation of the Patient Financial Services System.

The charge that the Secretary and the Under Secretary for Health issued to the Veterans Health Administration's Chief Business Office upon its creation 2 years ago was to provide focused leadership and direction to the multiple efforts comprising our revenue improvement strategy, and to further identify and pursue any actions necessary to ensuring achievement of the goals and expectations that have been established both within the Department and by those responsible for providing oversight and direction to our efforts. Consistent with that charge, we have a dynamic Revenue Action Plan encompassing a broad range of business processes that impact VA revenue activities.

To begin with, Mr. Chairman, I am pleased to report that collections continue to increase. Collections through June of 2004 now total $1.2 billion, which is some $129 million above last fiscal year's record collection rate as of the same date. We estimate this year's collections will be approximately $1.7 billion, representing the largest amount collected in the history of the revenue program. In addition, and consistent with industry measurement approaches, we are continuing to reduce gross days revenue outstanding, accounts receivable greater than 90 days, and days to bill.

Earlier this year, VA received recognition for its innovative and aggressive implementation of improved business processes from the National Automated Clearing House, NACHA, which represents over 12,000 financial institutions. NACHA awarded VA the 2004 Kevin O'Brian Automated Clearing House Quality Award for its e-payments system, a system that makes possible electronic receipt of remittance advices and payments.

In the information technology arena, we have made considerable improvement in operating processes and systems. We have developed automated billing utilities to support pre-registration and insurance verification and procured claims analyzer software to expedite clinical review of medical claims prior to submission to third party payers. In addition, we have implemented electronic claims generation capabilities for transmittal of claims to third party

health insurance companies and activated a first party lockbox to automatically apply payments from veterans to their outstanding copayment charges. The automation of this process has simplified the process for veterans, significantly reduced processing time, and freed facility staff to concentrate on follow-up of insurance claims.

Enhancements and changes to the Veterans Health Information Systems and Technology Architecture, known as VistA system, have simplified many of the manual processes once utilized. We are currently procuring a commercial off-the-shelf Patient Financial Services System that is intended to replace the VistA Integrated Billing and Accounts Receivable packages. This system, coupled with several of the ongoing revenue action plan objectives, will provide VA with a state-of-the-art software solution that expedites the billing and collection process by enabling the establishment of encounter-based patient accounts and the production of substantially more reliable industry-based reporting, analysis and decision support capabilities.

Upon creation of the CBO, VHA initiated a comprehensive assessment of ongoing activities within the revenue program. This assessment focused on industry best practices and resulted in the identification of a series of objectives in addition to those originally included in the 2001 Revenue Improvement Plan.

The immediate improvement strategies include development of the Medical Care Collections Fund performance metrics, an expanded focus on contracting for collection of accounts receivable over 60 days, and utilization of available contract support encompassing collections, insurance identification and verification, and coding.

Currently, over 70 outsourcing contracts are being used throughout VHA. Many of these are structured to allow contractors to retain a percentage of collections, which minimizes operational costs. Another significant accomplishment was to expedite the development and implementation of Electronic Data Interchange for third party claims to meet Health Insurance Portability and Accountability Act deadlines. The initial e-Claims software is operational at all VA facilities, and as of May 2004, more than 10 million claims have been generated.

An important mid-term improvement in the Revenue Action Plan, targeted for completion this fall, is to complete the Medicare Remittance Advice project. This project is designed to improve the quality of our many Medicare supplemental claims and to accurately identify deductible and coinsurance amounts that Medicare supplemental insurers calculate to determine reimbursement to VA. This effort will also allow VA to more accurately identify accounts receivable.

Other mid-term strategies include:

Activation in September 2003 of an electronic insurance identification and verification process that has confirmed the existence of an estimated 105,000 health insurance policies;

Software enhancements implemented in October 2003 to enable receipt of electronic payments from insurers;

Continuing development of encounter-specific inpatient accounts and further enhancements to the VistA clinical applications to col-

lect data elements required for complete and accurate billing information; and

A further advanced redesign of our Health Eligibility Center database to provide enhanced eligibility and enrollment functionality, improve data quality, and expand data sharing capabilities. When the redesign is completed in October of 2005, VHA will have a single enrollment database that will provide a register once capability, support the delivery of consistent and reliable eligibility information across VHA, and enhance and further automate the availability of compensation and award data.

A major tactical initiative currently underway is the phased piloting of Consolidated Patient Account Centers know as CPACs. These are modeled after private industry as an effort to enhance revenue consolidation efforts throughout VA. The initiative is targeted for deployment in September of 2005 and is designed to gain economies of scale by regionally consolidating key business functions. Once implemented, CPACs will serve to standardize business operations relating to back office functions.

Another major focus of our current long-term strategy is the implementation of an industry-proven Patient Financial Services System that will yield dramatic improvements in both the timeliness and quality of claims and collections.

A comprehensive reassessment and analysis of the PFSS project plan and associated timeframes has recently been completed to identify in detail the work and actions necessary to successfully blend the commercial PFSS system with VistA and our billing and collection work processes.

A further outcome of the reassessment has resulted in changing the project from being matrix-managed to a single point of accountability-managed project under my direction and leadership. VA's Chief Information Officer, Mr. Robert McFarland, will provide additional oversight and monitoring to ensure the project stays on schedule. Because of the analysis and the corresponding adjustment in project timelines and leadership, we are confident that we will be able to successfully implement PFSS within the established timeframes.

This very complex project is targeted for rollout at the first test site in VISN 10 in Cleveland in October of 2005, with subsequent rollout to the remaining four VISN 10 test sites.

Refined cost estimates for the first pilot sites in Cleveland and Dayton are estimated to be $73.8 million. A preliminary estimate for the remaining pilot sites is an additional $30 million. WE are working diligently to refine the preliminary estimate and to estimate enterprise-wide costs.

Due to its scope and complexity, this project is not without significant risk. VHA must make substantial changes across a large number of VistA applications to integrate with the commercial PFSS product. Therefore, we are using independent consultants to verify and validate our plans and to perform a thorough risk analysis. We are also incorporating lessons learned from the CoreFLS project to improve the likelihood of successful outcomes in PFSS. We believe these actions will result in a successful demonstration project that we can subsequently implement throughout VHA.

In conclusion, Mr. Chairman, we have seen significant improvements both in collection and overall performance, and we are optimistic that with the continued implementation of the revenue action plan, VA collections will continue to improve.

However, we must also continue to improve our performance in prospectively identifying veterans with billable health insurance. We must continue to improve training and educating staff, improving the association of service-connected disability to treatment, expanding clinical documentation, and accurately coding and timely billing for reimbursable services. We must continue to monitor and implement industry beset practices and further expand communication with all of our payers.

Vital to these many efforts is the continuing dedicated support of VA leadership, acceptance of responsibility and accountability by VA leadership, and the assignment of stringent performance measures and incentives. As we continue to improve in these areas, we will be serving the best interests of both the Department and the veterans we serve by increasing the available resources we need to provide them the high quality health care they deserve.

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

[The prepared statement of Mr. Ruyle appears on p. 65.]

Mr. BUYER. Mr. Ruyle, I gave you great liberty. And I would say, Mr. Secretary and Mr. Ruyle, your words are really a breath of fresh air. They're all the right words.

Mr. Davies, you are now recognized.

STATEMENT OF EDWARD C. DAVIES

Mr. DAVIES. Mr. Chairman and members of the subcommittee, thank you for the opportunity to address you today on Unisys' role as the prime contractor for the VA PFSS project.

My testimony today will cover the following topics: Progress since the last hearing. Key milestones. The PFSS technical solution. Risk management and success strategies.

At the March 17 hearing, I testified that Unisys and the VHA Office of Information, or OI, had analyzed gaps between the current systems and the target future flows to identify barriers to success. At that time Unisys stated that these issues were the focus of ongoing discussion among Unisys, the Chief Business Office, OI and VISN 10 leadership.

Since March, a combined team has completed detailed requirements analysis for the COTS implementation, the VistA modifications, and for systems integration. We have conducted additional COTS testing, obtained additional user feedback on initial system design and capabilities and begun change management activities.

We have also identified project risks and developed mitigation strategies. I want to stress that we have consensus from all stakeholders on these activities. Notably, the VA has now identified a senior executive, Mr. Ruyle, as the Chief Business Officer to address all PFSS-related issues. The Unisys executive and single point of contact remains Mr. Joe Macies, a senior partner, who accompanies me today.

The Unisys VA team has developed two detailed, well aligned implementation plans that will guide our efforts. Unisys developed

the PFSS COTS implementation plan, while OI developed its plan for the required VistA legacy systems modifications and the VistA interface engine. We have identified the resources and skills required to execute the plans and are tracking progress weekly.

Finally, we have completed several analysis stage deliverables and moved into detailed system design. A critical requirement for the success of the Unisys and OI efforts has been the identification of dependencies or touch points. With each touch point, we have identified who is responsible for sending and receiving the required data, due dates, and what tasks are impacted. We plan to be ready for an integrated system test next May, user acceptance testing in June, and as Mr. Ruyle said, a Cleveland go live in October 2005.

After extensively testing the functional fit of the IDX solution in the VHA environment, we have thoroughly validated that this COTS product will perform as expected. We recognize that the VistA legacy system changes present challenges. We believe that strong project management and dedicated VHA OI resources are absolutely critical to that success. OI has pledged to commit the necessary resources, and we believe that they will be successful as long as these resources are dedicated to this effort.

Risks exist in any business transformation effort. The VA Unisys team has performed extensive risk analysis, and we have developed risk mitigation strategies and owners for each risk.

We believe that all the risks are manageable as long as adequate resources are dedicated to the project and project coordination between all stakeholders continues at the level seen while finalizing the Unisys and OI plans.

We believe this project will be successful because we have included best practice approaches from the start. Notably, we have assessed the gaps between the current system and the target future state flows to identify issues that will result in barriers to success.

We have involved users in the day-to-day detailed design of the system. We have developed a testing approach that includes the users during planning and design and requires VISN 10 users to test and accept the system before the pilot is implemented.

We have employed an approach to training that includes end users early in the process. We have identified data conversion issues and begun to attack them early in pilot development. We have aligned information security and access with the VA Office of Cyber and Information Security policies and guidelines, and we have aligned the system design and build with the VA Enterprise Architecture policies and guidelines.

We've also extensively analyzed the network capacity for the Cleveland system pilot to ensure sufficient bandwidth to support that pilot.

Mr. Chairman, we have the right solution. We have universal buy-in, a documented and agreed upon timeline, interdependencies and touch points and a detailed work plan. We have a single VA executive responsible for accountability for the program. We will have success if we all execute. We are eager and fully prepared to implement PFSS.

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

[The prepared statement of Mr. Davies appears on p. 70.]

Mr. BUYER. Thank you, Mr. Davies. Mr. Ray, you are now recognized.

STATEMENT OF KEN RAY

Mr. RAY. Mr. Chairman and members of the subcommittee, I have been asked to speak with you today about eAppeals, a company with which VISN 8 has contracted to enhance revenue collections for the care of veterans.

In early November 2003, the VISN 8 network director received a call from the eAppeals Company requesting a meeting to provide an opportunity to describe their processes for improving revenue from disputed health care claims.

On November 23, 2003, the VISN 8 staff met with eAppeals. The company described its electronic processes and how those activities would improve payments for claims that insurers had rejected or paid inadequately. The presentation described a process by which disputed claims would be submitted electronically without intervention on the VA's part. They stated that they were not a collection agency but a company that automated the processing of disputed claims by applying laws, rules and demographic databases.

The company described how they were successful in helping private sector health care facilities collect on claims that were problematic for them. Benefits as we saw them were to have no dollars expended unless collections were actually received. No VA staff would be needed to process disputed claims, and the process was electronic.

The decision was to try the product, starting with our Miami facility. The plan was to send claims that were no longer active accounts and that were taken off the books for various reasons. If successful in the Miami VAMC, the product could then be deployed to other VISN sites.

In January 2004, a contract was signed with eAppeals. The Miami VAMC wrote the contract which allowed other sites within the VISN to become part of our contract over time. In the contract, eAppeals receives 35 percent of dollars collected for those previously closed out claims. The first electronic submission to the insurance carriers occurred on March 19, 2004. From the first submission of claims valued at $8,800,000, a little over $300,000 has been collected to date.

On the basis of discussions with eAppeals, we expect more recoveries from that first submission as the process escalates. The Miami VAMC has also selected other submissions for lesser sums to insurance carriers.

The Tampa facility has just started working with eAppeals and is in the beginning stages of extracting data for submission to insurers. We expect the remaining four VISN 8 facilities to begin implementation of eAppeals process in the near future.

All facilities will be extracting closed-out claims for submissions. We are in discussions of developing a cost estimate for those that are not finalized.

In summary, to date, we have been able to collect additional dollars from the use of this vendor. The Miami facility has found the vendor very easy to work with, and communications have been ex-

cellent. Where problems have been encountered, eAppeals is there to help. Weekly meetings are held and the disposition of all appealed claims are well documented.

Thank you.

Mr. BUYER. You know, Ms. Hooley, I'm going to start with you if you're prepared, because I've got one thing I have to finish writing. You are now recognized.

Ms. HOOLEY. Thank you, Mr. Chair. Mr. Ruyle, I, like my chairman, appreciated what you had to say. I have a couple of questions. You obviously bear a considerable burden as the go to person of this project. And do you have all the authority you need at this time that is necessary to allocate resources to the PFSS project and get the job done?

Mr. RUYLE. I'm comfortable with the authority I have to get the job done, as well as the team that we've put together to get the job done.

Ms. HOOLEY. Do you work for the VHS—the VHA or the CIO? Who do you work for?

Mr. RUYLE. I work for VHA for the Deputy Under Secretary for Operations.

Ms. HOOLEY. Okay. Can you give us some idea as to what caused previous delays that resulted in the rebaselining of the PFSS milestones? Any clue?

Mr. RUYLE. Yes, I can. When the project was originally conceived, it was a concept. And so the initial plan was based on a concept. At that point in time, we didn't even have a vendor selected. So we had no idea of knowing what software we would interface with. Once we selected a vendor, we had to look at what their requirements, were, and determine what our requirements were to interface and to integrate the two systems.

The VistA system is very complex, as you know. It's a 25-year-old system, and it was designed primarily for clinical applications, not for financial applications. So we have to go in and touch with the software several individual packages within VistA. That's very time-consuming.

The other thing that we wanted to ensure was that we delivered the right solution and that it would work as designed. So we thought rebaselining that plan was absolutely necessary. There was no other way to do that without rebaselining it.

Ms. HOOLEY. Okay. I felt good when you were talking about, you know, we collected $129 million more this year.

Mr. RUYLE. Yes.

Ms. HOOLEY. But I need to put that in context. So did it cost more to collect that much?

Mr. RUYLE. Actually, our costs as we know them now are pretty consistent with the prior year. We agree with the GAO report that we need to standardize our cost to collect and identify for our field what should be charged on cost to collect so that we can get a handle on that.

Ms. HOOLEY. So we don't know if it cost—is that what you're saying? We don't know?

Mr. RUYLE. We know what is charged off as cost to collect. What we don't have within the VHA right now is a standardization from one medical center to another as to what they charge off on those

costs. We will have that shortly. We've been working since this past April with the Office of Finance to standardize that. The cost codes will be in our computer system by the beginning of October. We intend to give guidance to the field and hopefully by the first of the calendar year, we will be able to standardize so that everyone is at least reporting the same, and we will define for them what's appropriate to be reported as a cost to collect.

Ms. HOOLEY. Okay. And again, I'm trying to put this in context. I know what we're trying to do, but my question is, what's your best guesstimate? Did it cost more to collect that or about the same?

Mr. RUYLE. I'm told that it cost us about the same this year as the previous year.

Ms. HOOLEY. And then in the collection of this, you know, additional amount of money, which again, I think is terrific, but wanting to understand how it fits in the larger picture, was that—was there also an increase of numbers of people that needed to—I mean, were there more people in the system? Was there more money to collect? I mean, what other factors played into the addition of this $129 million?

Mr. RUYLE. I think two factors have gone into it this year, and while I can't give you exact numbers off the cuff——

Ms. HOOLEY. Sure.

Mr. RUYLE. We know the number of veterans that were——

Ms. HOOLEY. Well, just give me a sense of.

Mr. RUYLE. I'm sorry?

Ms. HOOLEY. Just give me a sense of. Were there veterans——

Mr. RUYLE. A lot more—a number of veterans were——

Ms. HOOLEY. Were the operations more expensive?

Mr. RUYLE (continuing). This year, and the other thing that has impacted an increase in collections is the reasonable charges that got—we are allowed to bill for reasonable charges now, which we weren't previously, and that started this past year. And we attribute a significant increase in our collections to being able to use reasonable charges rather than a per diem rate.

Ms. HOOLEY. Okay. Do you want to go ahead? And I've got a couple of others.

Mr. BUYER. Sure. You know, Mr. Ruyle, you have a different definition of the word "comfort" than I do. Either you are restrained by position or tactful, but if I have to go beg for money all the time, that's not comfort in my definition. So would I make you even more comfortable if I could give money, if you had money along with the authority in your personal opinion?

Mr. RUYLE. You're putting me on the spot today here. One is always more comfortable if they have money. (Laughter.)

Mr. RUYLE. In my personal opinion.

Mr. BUYER. Right. You see, I'm more interested in more comfort rather than just comfort. Would you concur with that, Mr. Secretary?

Mr. MCFARLAND. Yes, sir, I would.

Mr. BUYER. Very good. That's all you needed to say. To Secretary McFarland and Mr. Ruyle, would you concur with Mr. Davies' testimony that he gave to the committee?

Mr. RUYLE. Very much so.

Mr. MCFARLAND. Yes, sir, I would.

Mr. BUYER. All right. Mr. Ruyle, why was a comprehensive reassessment and analysis of the PFSS project plan required?

Mr. RUYLE. Would you restate? Why was an analysis?

Mr. BUYER. Why was your reassessment and analysis of the PFSS project required?

Mr. RUYLE. Well, that was basically what I explained a minute ago is the reason that we rebaselined it. We wanted to ensure the right solution was delivered and it would work as designed. The original concept—I mean the original plan was based on a concept.

At that point in time, we didn't even know who the vendor was. So it would be very hard to do a detailed plan not knowing what was required to interface and integrate with that COTS off-the-shelf product. A rebaselining would have had had to occur regardless of who was selected as a vendor I think.

Mr. DAVIES. Mr. Chairman, could I add to that?

Mr. BUYER. Sure.

Mr. DAVIES. One observation I have is that the original dates that were put out were top down type dates. They were established, I'm not sure where they were established, but they weren't based on the detailed bottoms-up assessment of what had to take place to complete the pilot.

And Mr. Ruyle is correct, it's because at the time it was conceptual in nature. Once they selected Unisys, once we selected the IDX COTS package, we could get into the nitty gritty details on how we were going to actually move this forward. That took a lot of dialogue with the different stakeholders across the VA, but once we've gotten that done, now we have what we're calling a rebaseline, but I'd almost look at this as the first solid baseline the VA has had on this program.

Mr. BUYER. And your contract is to design a system?

Mr. DAVIES. Design and implement the COTS solution.

Mr. BUYER. And when you say "and implement," does that also include user assistance?

Mr. DAVIES. We have some form of getting users ready in the basic contract, but not enough to have this fully implemented. We're discussing that with the VA right now, how to make sure that we have adequate deliverables in there, adequate focus on user training, et cetera.

Mr. BUYER. Now obviously this did not happen on your watch, Mr. Secretary, but why would we lend a contract that would not be inclusive of user assistance in the implementation? Did the VA assume that this was something they could just do in house, and now you're learning that they cannot?

Mr. MCFARLAND. I'm not sure, sir. I can tell you that the contract pre-dates Mr. Davies and myself, and Ted and I have had a discussion about how we're going to go through that contract and make sure that the deliverables in there are matched to the success of what we're trying to do. Training, as we learned in Florida, is a key ingredient——

Mr. BUYER. Right.

Mr. MCFARLAND (continuing). In how we implement any IT project. I would also add that I think it was rebased—one of the necessities of rebaselining was in the way in which we were man-

aging this. We are managing this in a method by which we were matrix managing it, and I don't think that was something we could do successfully.

Mr. BUYER. Hold on just a second. We have to figure what's happening here. We have two votes, a 15 and a 5, and it's the life here on the Hill. Four votes? Could somebody tell me what the four votes are? Go ahead, Ms. Hooley.

Ms. HOOLEY. So we're talking about time management here. Very quickly, Mr. McFarland, many of the problems with the IT system development could be a result of mismanagement. You've got failure of the HR Link system, delay with the VETSNET. You've got recent problems with CoreFLS pilot in Florida, late out of the gate start with the PFSS. What's changed regarding accountability and management of the IT development programs as to avoid the delays?

Ad to follow up, in 2002, Secretary Principi organized or reorganized the Office of the CIO. We were told it was to centralize authority and align administration of CIO under your office. What's the status of this reorganization? And do you make all the resource calls for the IT system?

Mr. MCFARLAND. The status of the reorganization is it effectively didn't happen. That's my opinion.

Ms. HOOLEY. Okay.

Mr. MCFARLAND. I think a total of 91 people were transferred from wherever they existed in the VA in the IT arena into the Office of Information and Technology. So, to me, that's effectively not happening.

Ms. HOOLEY. Right.

Mr. MCFARLAND. As to where we are today, we are in the process of trying to determine—right now I am in the process of trying to determine right now—where we should go with an organizational structure that will now allow the history that has appeared in this agency to continue.

I think the biggest problem is that we have never taken the time, in most of these projects that I've been able to look at in 5½ months, we have not taken the time to define the as-is state, determine whether the as-is state needs to be changed through standardization, then define the to-be state of where we want to go, and from that point forward, decide what kind of implementation plan is necessary to get to the to be.

That seems like a relatively simple process, but it is not necessarily occurred in this environment. And I think personally, in my limited knowledge, that is why you've had the problems you've had. Okay.

Ms. HOOLEY. Thank you for your honesty. There are a ton of follow-up questions now that you've said that that I would like to ask, but I'm going to go to what Mr. Ray said about eAppeals. I mean, is that different—I mean, this company is collecting really dead files, I mean files that have not been opened, I don't know, for 3 years, or. Is what you're trying to do different—I mean, hopefully you won't have as many dead files. But what you're trying to do is different than what this particular company is doing, which is going in and sort of cleaning up whatever they can clean up.

Mr. RUYLE. It's different in that we hope to prevent us from being in a position where they're able to do that.

Ms. HOOLEY. Well, you don't have as many. I mean, you're always going to have some——

Mr. RUYLE. I think in the short term——

Ms. HOOLEY (continuing). Dead files.

Mr. RUYLE (continuing). Totally different from what we've seen so far from the results of Miami, it certainly appears successful at this point in time.

Ms. HOOLEY. Boy, would I like to have some more time to question you. Mr. Chair?

Mr. BUYER. All right.

Ms. HOOLEY. I'd love to have Mr. McFarland back.

Mr. BUYER. We have a full committee markup in here at one o'clock. We have four votes. I'm going to miss the previous question, and I'll hit the rule and the two other fives. That will capture 15. Break 15, be back for 10. So after the last vote, I'm going to reconvene.

Ms. HOOLEY. Okay.

Mr. BUYER. Okay? And I'll try to knock out a few other questions.

Ms. HOOLEY. Okay. All right.

Mr. BUYER. Is that all right, Ms. Hooley?

Ms. HOOLEY. Certainly.

Mr. BUYER. I would like your counsel, Mr. Secretary, on an idea to bring competition into the marketplace on pilots. So if we have Unisys right now and they are as eager to be successful and to leverage the model, given their testimony and your testimony, and the concern that Mr. Davies had expressed to me earlier before the hearing is, is that we need to make sure that we have the resources so we can actually hit the timelines, so that you can actually get the data that you need, right? And you can develop these user assistance things that are required.

But if there is an at-risk entity out there that is willing to come into the marketplace and say, we're going to do the same thing, not for a VISN. We'll do it for a medical center with some of their satellites, and they also do very similar—here are the systems that can be used, here are the efficiencies which they bring—instead of paying up front for which we are doing with regard to Unisys, they receive their payment on the back end. So we don't sacrifice this present project, because I want it to be successful. If you have an idea for something, you don't want it to fail. So I don't want this to fail. But I just was curious what your thoughts are with that idea.

Mr. MCFARLAND. Well, I come from the private sector, so I'm naturally in favor of competition. I believe the strong survive and the weak tend to fall. I would say as long as we had—we the VA—had an organizational structure and the resources to properly audit and apply competitive processes like this, then there's certainly value in doing it.

The only thing I would warn us against is not having the resources and the organizational structure to allow us to manage two Unisyses toward that goal. because putting a secondary Unisys on

top of this at a point where we couldn't manage it would not guarantee that we could even select the best of the two competitors.

Mr. BUYER. So if I do that, Mr. Walsh and I coordinate to have appropriations for you to be able to achieve that so it does not sacrifice Unisys, all right? Is that what you're telling me?

Mr. MCFARLAND. I think that's exactly what I'm saying. And I also believe that in order—I would want to put some of the onus on the vendors, candidly, up front, which is typically not what we do here, and to be sure that we get the vendor as locked in to successful implementation as we are, candidly.

Mr. DAVIES. Can I make a comment?

Mr. BUYER. Well, Unisys has a reputation here too. They work with a lot of different departments and agencies here of the federal government, and they also must feel very uncomfortable when they receive a contract, a particular bid and then it keeps growing. But what people don't realize is, I mean, members come up and ask me questions about the contract, or even Mr. Walsh, about what's going on here, you've got to go back to what did the original contract say, versus where do you want to be in order to be successful.

Mr. MCFARLAND. Right.

Mr. BUYER. Mr. Davies?

Mr. DAVIES. Yes. I'd like to just quickly comment on your question to Mr. McFarland. As the prime contractor on this, we really want this project to be successful, and I will give a personal opinion, I'm okay with competition on this. Please don't take my comments as I don't want to compete, although we did compete to win the initial contract already, but I'm okay with more competition.

The biggest concern I have is that over the past few months, the biggest risk we've identified to our success right now is not a financial risk. I think the VA is making the resources available they need to, and with your help, they will get more dollars to do this. It's the actual people resources to actually make the changes that have to get made in VistA to make this solution work.

And no matter what vendor you bring in, in a separate solution, no matter how you place it, they're still going to have to work with VistA and they're still going to have to modify VistA to make their solution work. And we were barely able to get the resources from OI today to support our pilot.

So trying to get OI to step up and have resources for another pilot I think would be very, very challenging and risky. So it's not a dollar resource, it's a people resource as much as anything else that is a risk area.

Mr. BUYER. Now within PFSS, Mr. Davies, what Mr. Ray has testified about eAppeals, you're incorporating that in your model, are you not?

Mr. DAVIES. We're not actually going to go out and do the collections at the end of this, no.

Mr. BUYER. Well, I understand that. But you're putting that in the process?

Mr. DAVIES. Yes. Absolutely. As you know, it's part of the transformation, the business transformation that we are supporting with this, yes. But it's not part of our contract to go collect uncollectible bills.

Mr. BUYER. Oh, I understand that. This is the Oversight and Investigations Subcommittee of VA. Why I repeat that is, is that we sometimes have to ask tough questions, and it's extremely important that we do that, and that Mr. Ruyle, you—well, I'll take it not from Mr. Ruyle. I should really turn to you, Mr. Secretary.

I was given a document from General Counsel asking a lot of due diligence questions with regard to eAppeals and the company as to they are and who owns them and do they have the proven track record and reputation. There is a relationship right now with regard to a pilot. But before you leverage anything beyond that, please coordinate with the General Counsel of VA.

I'm not going to go through all of this, because it's some pretty serious allegations, and I think it would be unfair to the company for me to do this publicly. But permit the company to answer, and you do your due diligence with regard to very serious questions in their business relationships and with people whom they have had these relationships with. It needs to be drilled down, Mr. Secretary, okay?

Mr. MCFARLAND. You have my commitment to do that, sir.

Mr. BUYER. All right. Thank you. We're going to break. We will reconvene at 12:30. We stand in recess till 12:30.

[Recess.]

Mr. BUYER. All right. The subcommittee will come back to order. And I want to make sure that Unisys, that you are comfortable with the tracking system for you to achieve your milestones?

Mr. DAVIES. Yes, we are.

Mr. BUYER. Okay. Secretary McFarland, too, are you comfortable with the timelines that Unisys is using?

Mr. MCFARLAND. Yes, sir, I am.

Mr. BUYER. And you are in agreement with Mr. Davies with regard to all of the data being supplied in a timely manner? Is that correct? Data requested in order to achieve milestones as necessary. And you've got that good understanding with Unisys that that will happen.

Mr. MCFARLAND. Yes.

Mr. BUYER. Because if it doesn't get there, they won't reach their milestones.

Mr. MCFARLAND. They can't do their job.

Mr. BUYER. And likewise, the resources don't get there in a timely manner if it doesn't happen. Right?

Mr. MCFARLAND. Absolutely.

Mr. BUYER. If you have to beg too much or too hard, just let us know. Right? I'm just trying to drill this down in the short time we have here. We don't have a lot of legislative days left, when you look at all this. We break, don't come back till the first week of September.

I'll continue working with Ms. Hooley and have discussions with Mr. Walsh. And I want to have some follow-up with you, Mr. Secretary.

Mr. MCFARLAND. Yes, sir.

Mr. BUYER. If I can. You also had mentioned last time you were here, you mentioned that you were doing an ongoing review of all IT systems. Is that being completed?

Mr. MCFARLAND. It is not complete yet. We're in the middle of our OMB 300 process, and I'm trying to do some review as we look at the OMB 300's that are being prepared for the budget cycle in 2006, which is what's going on right now. Candidly, I heard about a project today for the first time. So I'm still in my learning and discovery process. But I'm trying to take the largest process—or largest projects first and work through those.

I would tell you that I am not completely through. There are 53 large OMB 300s projects that the VA has right now, and I'm trying to get through each of those and trying to understand where we are with them, what our success rate has been so far, what we're spending on them. But I'm plodding through there as quickly as I can, sir.

Mr. BUYER. Mr. Davies, I've been informed that with regard to user assistance, there is a proposal for you to work or perhaps even partner with the unions. Can you tell me about that?

Mr. DAVIES. We've been involved in representation from the unions from the start. I'm not sure how you mean "partner." We've been working closely with them to make sure that we understand what their requirements are, what veterans' concerns are with the billing statements themselves, but I'm not sure what you mean by partnering.

Mr. BUYER. I guess what I'm trying to find out is, earlier I had asked the question about your design and implementation, but you're in negotiations with regard to user assistance.

Mr. DAVIES. Yes.

Mr. BUYER. Part of that user assistance is to make sure that those employees are comfortable with that system which they're about to employ, so we don't run into problems like we also had down at Tampa. You're in discussions with the union to bring them as a partner in this endeavor?

Mr. DAVIES. Yes. We are working with the union. We are working with the users themselves, absolutely.

Mr. BUYER. VistA, Mr. Davies. When we take your project to its end state, what happens to VistA?

Mr. DAVIES. Are you talking about when we go to the end of the pilot?

Mr. BUYER. Yes. Go to the end of the pilot.

Mr. DAVIES. When we go to the end of the pilot, we are working with the next upgrade on VistA, and it's not the rebaselined VistA, it's not the replatformed VistA, it's the current VistA system with the next iteration. We're going to demonstrate that it works in the VistA environment, and that's during the current pilot.

Mr. BUYER. I guess what you're trying to do is define an end state on what you have to work with today, right?

Mr. DAVIES. Correct.

Mr. BUYER. Which requires pretty good coordination there with the Secretary and other IT ongoing projects doesn't it?

Mr. DAVIES. Correct.

Mr. BUYER. Right?

Mr. DAVIES. Yes.

Mr. BUYER. Which means that this contract that you have has a lot of flexibility in it, right?

Mr. DAVIES. Well, it's a fixed price contract.

Mr. BUYER. How are you going to be able to get to an end state if they change VistA on you in the time period?

Mr. MCFARLAND. Sir, we will not be changing VistA in the time period that we're talking about doing this project.

Mr. BUYER. Okay.

Mr. MCFARLAND. And in fact, to be candid with you, I have initiated or asked that OI initiate an IV&B to look at the whole rehosting of VistA to be sure that we are on track with the kind of systems implementation and design that we can take forward. So I don't believe we will be changing VistA dramatically in the timeframe that we need to do this pilot.

Mr. BUYER. All right. Thank you. That helps me. Did Ms. Hooley have any follow-up, do you know? All right. I would ask, Mr. Secretary, that you cooperate with the GAO as they conduct their oversight of the project.

Mr. MCFARLAND. I'd be pleased to do that, sir.

Mr. BUYER. Thank you. Mr. Secretary or Mr. Ruyle, how is the VA going to capture the cost of staff time associated with the PFSS system and include this in the cost associated with third party collections?

Mr. RUYLE. Let me make sure I understand that question. How are we going to capture the staff time associated?

Mr. BUYER. Mm-hmm.

Mr. RUYLE. Well, we have some employees that are dedicated strictly to the PFSS project, both at VISN level and CBO level and OI level. What we're trying to do with this is to associate anything related to the project—I don't want to say under one accounting system, but we want to be able to track all of the costs related to PFSS and the project.

We've designated an individual responsible for that. We have a single budget so that anything that's related—related is hard in the VA. I mean, major relations I should say, will be attributed to that project. If someone happens to do something very minor associated with it, I wouldn't expect to capture those costs. But the major costs that are associated with it will be under one control point and will be subdivided from that control point to the VISN, to OI and to the CBO.

Mr. BUYER. My last question, Mr. Secretary and Mr. Ruyle, have you been able to look at a draft of the IG report with regard to Tampa on CoreFLS?

Mr. MCFARLAND. I've gone through it in detail, yes sir.

Mr. BUYER. Okay. And have you been able to take—done an assessment with regard to your lessons learned and how it could apply to this contract with Unisys?

Mr. MCFARLAND. I have been able to take a lot from that IG report, and I feel strongly that we can avoid a lot of the issues we had with CoreFLS in this project. Just understanding the as is gets us off to a much better start than we did at CoreFLS. And then understanding where the to be is, which is what Unisys is really doing. That to me is a significant advantage to us in this project that I don't thin we did in CoreFLS.

Mr. RUYLE. To carry that one step further, we are developing an action plan in the CBO to address those individual lessons learned

from that so that we have a specific plan to address each one of them and identifying a responsible individual for each of those also.

Mr. BUYER. All right. There will be written questions offered from Ms. Hooley, minority. Oh, wait. We'll just pause for a second. I'll strike that from the record. Ms. Hooley, I was able to ask a series of questions. I'm comfortable I'll do some follow-up written questions, but at this time if you have any follow-up questions or would like to submit written questions for the record, there are no objections. Ms. Hooley?

Ms. HOOLEY. Yes, Mr. Chair. I understand you have a document I don't have. Is that correct?

Mr. BUYER. I have a document. I do.

Ms. HOOLEY. Are you willing to share that with me?

Mr. BUYER. I'll be willing to have an offline discussion with you.

Ms. HOOLEY. Okay. And then I have a series of questions, but what I will do is just ask these for written responses.

Mr. BUYER. Sure. That would be great.

Ms. HOOLEY. Do we have time now, or—I think written responses.

Mr. BUYER. That would be fine.

Ms. HOOLEY. Okay. Thank you.

Mr. BUYER. Gentlemen, thank you very much. I don't know what your schedule is between now and Friday. I leave on Friday. If you could review your schedule and if our two schedulers can talk about a time when we can have a conversation.

Mr. MCFARLAND. I would be happy to.

Mr. BUYER. We'll see if we can make that happen.

Mr. MCFARLAND. I will contact your office and mine.

Mr. BUYER. That's great.

Mr. MCFARLAND. Thank you.

Mr. BUYER. The hearing is now concluded.

[Whereupon, at 1:03 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN BUYER

Good Morning. Today's hearing is the fourth oversight hearing held by the Subcommittee on the VA's third party collections program.

The good news is that collections have risen from $690 million in fiscal year 2002 to $1.489 billion in fiscal year 2003. On the flip side, there was $1 billion in unbilled care in fiscal year 2002 and $516 million in fiscal year 2003. How was this allowed to happen? Even though the amount was reduced by almost half, the better question is, how much has been collected?

Our last hearing on this issue was fourteen months ago. I think it's important that we take a look at where we are today in terms of what the VA told us would be accomplished and what has actually been completed.

At our last hearing, former Deputy Secretary MacKay talked about the need to use "industry best" performance practices to ensure reliable registration, insurance identification and verification, and pre-authorization processes. These "best practices" were incorporated into the 2001 Revenue Cycle Improvement Plan. Today, we hope to learn when the VA anticipates completion of this plan, which was designed to improve core business processes. To date, 17 of the 24 proposed initiatives have been completed. What is the status of the most difficult last seven initiatives?

The other major program that was touted by the VA is the Patient Financial Services System demonstration. The PFSS pilot project was originally scheduled for implementation in late fall of 2003. The pilot is designed to test PFSS in order to demonstrate how an integration of commercial patient management and financial software programs is suppose to significantly improve VA's third party collections by capturing and consolidating inpatient and outpatient billing information. Unisys Corporation was selected by the VA to implement the pilot project.

Today, we will receive an update on the PFSS pilot project. In particular, we will examine why the November 2003, projected implementation date was missed, and why it was necessary to rebaseline the entire project in June 2004 with new milestone dates. Don't get me wrong, I do not believe we should rush through this process. At the same time, I don't think sound project management practices were used by VA in the initial stages of the project. This appears to be a common reason for repeated failure of almost every major IT initiative in the VA.

Frankly, it concerns me that the VA did not have a business plan prior to startup of the project and that an analysis of VA's current business process was not accomplished until June of 2004.

It appears the poor program management practices that led to the virtual meltdown of CoreFLS a major IT initiative at Bay Pines, FL have also plagued the PFSS project.

As we know from past hearings, there are several problems that have been repeatedly identified in the last 8 years which contribute to the VA's poor performance in collections. They include missed billing opportunities, huge billing backlogs, and undocumented or inadequate follow-up in pursuit of accounts receivable. The GAO and the VA IG will share their findings with us on what the VA has done to improve in these areas.

Another area that is an integral part of the collections process is how much it costs to collect. The GAO will provide us with its analysis of why the VA still does not know how to calculate the cost of its collections efforts.

I look forward to hearing the testimony of our witnesses.

United States Government Accountability Office

GAO

Testimony

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

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, July 21, 2004

VA MEDICAL CENTERS

Internal Control Weaknessess Impair Third-Party Collections

Statement of McCoy Williams,
Director, Financial Management and Assurance

GAO-04-967T

July 2004

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Accountability · Integrity · Reliability

Highlights

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

VA MEDICAL CENTERS

Internal Control Weaknesses Impair Third-Party Collections

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.

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.

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.

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.[1] 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.[2] 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.[3]

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.[4]

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

[3]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).

[4]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).

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.*[5] 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.

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

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[6] 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.

[6]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.

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

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.

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.

Accounts Receivable Not Pursued in a Timely Manner

VA's Handbook sets forth the requirements for collection of third-party accounts receivables.[7] Also, in 2003, the VHA's Chief Business Office issued the *Accounts Receivable Third-Party Guidebook* that lays out more detailed procedures.[8] 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

[7]VA Handbook 4800.14, *Medical Care Debts*, Department of Veterans Affairs, (Washington, D.C.: Dec. 8, 2003).

[8]*Accounts Receivable Third-Party Guidebook*, Department of Veterans Affairs, 2003.

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).

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.

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.

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.

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

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.[9] 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

[9]An encounter is defined as a single medical treatment.

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.[10]

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[11] 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.

[10]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.

[11]A private company that contracts with Medicare to pay Medicare Part A and some Part B bills.

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.

Contacts and Acknowledgments

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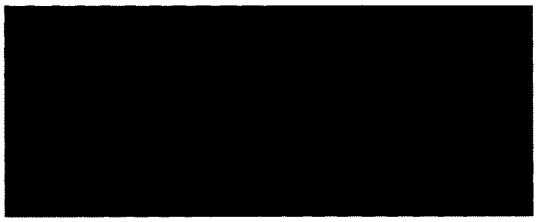

STATEMENT OF
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OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
PROGRESS IN ITS THIRD PARTY COLLECTIONS PROGRAM
JULY 21, 2004

Mr. Chairman, and Members of the Subcommittee, I appreciate the opportunity to be here today and to report on our ongoing work concerning the Department of Veterans Affairs (VA) Medical Care Collections Fund (MCCF) Program. During the past several years, the Office of Inspector General (OIG) has dedicated significant resources to identify opportunities to improve MCCF collections and revenues and to find solutions for the financial and management challenges facing the Department's MCCF Program.

In February 2002, we issued an audit report on the Department's MCCF activities (*Audit of the Medical Care Collections Fund Program*, Report Number 01-00046-65, dated February 29, 2002) that identified opportunities to increase collections. We found that the Veterans Health Administration (VHA) could increase Fiscal Year (FY) 2000 collections by $135.2 million after collections remained relatively stagnant for a 3 year period. Additionally, my auditors found that clearing the backlog of "unissued bills" totaling over $1 billion would result in additional collections of $368.4 million.

We made several recommendations to improve the collection process, increase revenue for VA, and to improve financial management practices. Recommendations were made to the Department to improve the quality of medical record documentation needed to bill for services, establish performance standards, and strengthen pre-registration efforts to identify insured patients, insurers, and insurance information.

We also reported on problems with the accuracy of coding on bills sent to insurers for collection in February 2002. Our report (*Evaluation of VHA's Coding Accuracy and Compliance Program*, Report Number 01-00026-68, dated February 25, 2002), showed that VA employees needed to focus their attention on reducing coding error rates for outpatient visits and to improve internal controls.

The review found that about 50 percent of the 570 outpatient visits reviewed contained coding errors. Recommendations were made to VHA to better educate clinicians on the necessary documentation requirements to accurately bill for services rendered, and to require managers to establish incremental goals to improve coding accuracy.

Similar issues were discussed with the Subcommittee at a hearing held in September 2001 where we reported that the effectiveness of billing reasonable charges relies upon accurate documentation of the medical care provided, use of consistent business processes, and compliance with policies and procedures. Although we reported collections were increasing in FY 2001, our audit results showed potential for significant additional collections. Many of these same conditions persist today, including missed billing opportunities, billing backlogs, accounts receivable management weaknesses, and procedures to identify and verify patient insurance coverage.

Since these reviews and the September 2001 hearing, VHA has aggressively worked to improve their collection efforts. As demonstrated in FY 2003, VHA increased revenues, met our reported projections, and collected about $804 million. These results validated our findings and recommendations for enhancing monetary program recoveries through aggressive collection efforts.

While VHA has increased its collections, we continue to identify opportunities to increase MCCF revenues, and the need to improve internal controls to strengthen billing and monitoring practices. Our most recent work addressing MCCF collection activities has been conducted as part of our Combined Assessment Program (CAP) reviews. From March 31, 1999, through June 30, 2004, we issued about 50 CAP reports on VHA medical facilities that highlighted MCCF collection activities. During these reviews, we identified control deficiencies that have hindered VA's ability to maximize its revenues via collections from health insurers. Recent CAP reviews continue to show the need for VHA to improve processing and collections of accounts receivable in such areas as unbilled and delinquent accounts receivable, coding for medical services, and to ensure timely follow-up of accounts receivable.

For example, our CAP review performed at the VA Medical Center (VAMC) in Houston, TX (Report Number 03-01379-115, dated June 19, 2003), identified coding inconsistencies. During the review, we judgmentally sampled 25 accounts receivable valued at about $1.2 million. Three of the bills valued at about $197,000 contained coding errors that resulted in insurance carriers being under billed for almost $96,400. VAMC staff needed to ensure that only bills with correct diagnostic and procedure codes were sent to insurers for collections. The erroneous bills have been amended and re-issued with correct information, and

plans have been developed by the VAMC to review and correct coding of other bills.

Our CAP review at the VA Medical Center in Togus, ME (Report Number 03-02729-120, dated April 2, 2004) identified almost 26,000 unbilled claims for episodes of care totaling approximately $6.5 million for a 1 year period, September 26, 2002, through September 26, 2003. The facility's MCCF Coordinator estimated that approximately 30 percent of the unbilled episodes, valued at more than $1.9 million, represented billable episodes of care. Applying the medical center's FY 2003 collection rate of 28 percent for billed care, we estimated that MCCF staff could have collected at least $542,000 from third party insurers. We also examined a judgment sample of 10 receivables over 90 days old valued at about $410,000, and found that MCCF staff had not aggressively followed up on 4 of the accounts valued at almost $233,000 prior to referring them to a collection agency.

The CAP review at VA's Ann Arbor Healthcare System (Report Number 03-02729-140, dated May 6, 2004), identified about 13,000 unprocessed claims for episodes of care totaling approximately $7.2 million listed in the "*Unbilled Amounts Report*" dated September 5, 2003. As mentioned in earlier recommendations made to the Department in 2002, actions were needed to timely bill for services.

Other bills were identified that were delayed nearly a year after the receivables were established before being entered into the VAMC's financial management system. Timely action is essential since no funds can be recovered until the insurance companies have been billed. In both the April and May 2004 CAP reviews described above, we recommended the Veterans Integrated Service Network (VISN) Directors ensure that MCCF Program employees bill third party insurers for outpatient episodes in a timely manner and take action to aggressively pursue MCCF accounts receivable. We will continue to follow-up on these recommendations until all issues are resolved.

We will soon issue the results of our CAP review on the VA Southern Nevada Healthcare System in Las Vegas, Nevada, where we identified coding and billing accuracy as an area needing improvement. As part of this review, we reviewed patient medical records corresponding to 20 unpaid bills valued at about $234,200. We verified coding errors detected by the healthcare system staff on 13 of the 20 bills (65 percent) and found that 6 of the errors affected the billed amounts. Five bills were assigned diagnostic and procedure codes with higher reimbursement values than what was supported by medical record documentation. As a result, the bills were overstated by $1,725. The remaining bill had been assigned codes with

a lower reimbursement value, resulting in the bill being understated by $425. These coding errors caused the 6 bills to be overstated by a net amount of $1,300.

At this same site, we also identified 40 outpatient care encounters that had missing or insufficient clinical documentation. If all 40 encounters had sufficient clinical documentation available for billing, the healthcare system could have potentially collected an additional $13,000 in revenue. Better efforts were needed to ensure progress notes transcribed by physicians are attached to the patients' charts as required, and that attending physicians countersign the resident physician notes where appropriate. Complete medical record documentation and improved coding and billing processes would have resulted in increased reimbursements. We will follow-up on these recommendations until all actions have been completed.

Our CAP report on the VAMC in Chillicothe, Ohio (Combined Assessment Program Review of the VA Medical Center Chillicothe, Ohio, Report Number 04-00928, dated July 15, 2004) concluded that medical center management could further improve MCCF program results by strengthening billing procedures for fee-basis care, establishing procedures to ensure bills for outpatient and inpatient care provided prior to July 2003 are processed before insurance filing deadlines expire, billing for optometry services, and ensuring physicians adequately document care provided in the medical records. At this facility we identified additional billing opportunities totaling at least $27,000, with estimated collections of about $13,000.

To determine if fee-basis medical care was billed to patients' insurance carriers, we reviewed a judgment sample of 32 claims totaling about $58,000. Of these 32 claims, 23 were not billable to the insurance carriers either because the fee-basis care was for service-connected conditions or the care was not billable under the terms of the insurance plans. MCCF staff at the VAMC had appropriately billed for five claims. However, we found additional billing opportunities totaling almost $13,300 for four other claims. Follow-up reviews will be conducted until these issues are resolved.

Through the use of CAP reviews and periodic follow-ups with the Department, we continue to monitor efforts to improve the Department's MCCF Program. Currently, the Department is in the process of implementing a Revenue Action Plan resulting from our reviews and reviews conducted by the Government Accountability Office that includes 16 actions designated to increase collections by improving and standardizing collection processes.

The Department's Revenue Action Plan includes objectives to implement the Patient Financial Services System (PFSS). This system is a Department priority, Congressionally mandated business improvement effort designed to integrate a

commercially-off-the-shelf health care billing and accounts receivable system in the VHA with an initial objective of replacing legacy integrated billing and accounts receivable applications. According to VHA, the pilot project will create a comprehensive business solution for revenue improvement utilizing improved business practices, commercial software, and enhanced VA clinical applications.

As of June 2004, Department status reports showed that the analysis phase of the PFSS project was near completion and the project is about to enter the design phase. VA will use this design phase to obtain input from technical and business experts, and obtain user input throughout VA in order to gather requirements for building the dictionaries, screens, and edits that will complete the software design. The new timeline for delivery at the first test site in VISN 10 is October 2005.

While development of PFSS is ongoing, VHA has been exploring other opportunities to improve revenue cycle practices through standardization. VHA has designated Business Implementation Managers for each VISN to enhance accountability for patient care administration and revenue cycle matters.

VHA workgroups have also been formed to assess critical needs and to catalog best practices. For example, VISN 5 devised a best practice to enhance their insurance identification practices and potential collections. Pre-registration telephone calls are made 7 days in advance to remind patients of upcoming scheduled appointments and to update their demographics, including health insurance provider information. Collections have improved as a result of this best practice. For example, VHA management has reported that the Consolidated Pre-registration Unit in VISN 5 has increased overall collections from $11.7 million in FY 2000 to $27 million in FY 2002 by identifying additional billable cases. In fact, since VHA dedicated program staff responsible for verifying coverage and benefits of each new billable insurance case identified through pre-registration telephone calls in July 2000, VISN 5 staff has verified over 44,000 new insurance cases.

VISN 6 has implemented a centralized check-in process to improve the accuracy and timeliness of insurance information. Patients check in at one centralized area before going to clinical appointments. At the centralized area, intensive screening of demographics, insurance information, and future appointments are discussed with the patient. The patient does not have to go through the same procedures for the next 90 days unless he or she has a change in demographics or insurance. This enhanced process contributed to a 32 percent increase in collections valued at over $20 million, as accurate insurance information allows for more efficient follow-up of accounts receivable. The centralized check-in best practice resulted in the identification of over 68,000 new insurance policies, resulting in an increase in over 154,000 bills processed when comparing FY 2002 results to FY 2003.

It is important that the Department implements its Revenue Action Plan and strengthens MCCF processing and collection practices. The plan identifies improvements needed to address weaknesses in coding and billing accuracy. We had received and reviewed allegations of improper or fraudulent MCCF billings to the American Association of Retired Persons (AARP).

In December 2003, we issued a report entitled, "*Evaluation of Medical Insurance Billing Practices at VAMCs Bedford and Northampton, Massachusetts*" (Report Number 03-00396-36, dated December 1, 2003). The AARP Health Care Options group, administered by the United Healthcare Insurance Company referred 35 potentially improper VA MCCF bills to the Insurance Fraud Bureau of Massachusetts. According to AARP's allegation, VAMC's Bedford and Northampton staff submitted claims for ineligible services. These included billings for outpatient visits to obtain drug refills, and physical therapy treatments for which there were no records of treatment plans. As reported in prior reviews, we also found outpatient visits that were billed for higher levels of care than that supported in the medical records.

While our review did not substantiate fraudulent activity, we substantiated AARP's allegation of improper billings. Medical record documentation showed that although the patients in these cases received medical services on the dates billed, VAMC employees misinterpreted coding and billing guidelines and made poor billing decisions. Management implemented use of coding and billing scrubber software to ensure future bills were proper, improved education and communication among employees on what AARP covers, and began a constructive dialogue with AARP to address billing issues. VISN 1 also reviewed payments received on the bills and made refunds where appropriate.

The VA Under Secretary for Health agreed with our recommendations and provided acceptable implementation plans for all recommendations. In June 2004, VHA provided an update on follow-up actions from meetings with AARP. We are currently assessing the adequacy of the actions taken in response to our recommendations. This includes VHA's efforts to monitor follow-up actions from the meeting with AARP and to ensure all billing concerns are resolved. We also are reviewing actions taken to provide appropriate guidance to facility staff to ensure that solutions to current billing issues (e.g., billings for outpatient visits for prescriptions, annual examinations, and physical therapy visits) are effectively implemented nationwide.

In conclusion, the Department increased collection revenues, but more needs to be done. While VA has addressed many of the concerns we reported over the last several years, our most recent work continues to identify major challenges where

VA could improve collection activities. This completes my statement, Mr. Chairman. I would be pleased to answer any questions you and the Subcommittee members may have today.

STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

JULY 21, 2004

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to inform you of the continuing progress, challenges, and future direction of the Department of Veterans Affairs (VA) revenue program and to update you on the current status of the implementation of the Patient Financial Services System (PFSS).

The charge that the Secretary and the Under Secretary for Health issued to the Veterans Health Administration's (VHA) Chief Business Office (CBO) upon its creation two years ago was to provide focused leadership and direction to the multiple efforts comprising our revenue improvement strategy, and to further identify and pursue any actions necessary to ensuring achievement of the goals and expectations that had been established both within the department and by those responsible for providing oversight and direction to our efforts. Consistent with that charge, we have a dynamic Revenue Action Plan encompassing a broad range of business processes that impact VA revenue activities.

To begin with, Mr. Chairman, I am pleased to report that collections continue to increase. Collections through June 2004 now total $1.2 billion, which is some $129 million above last fiscal year's record collection rate as of the same date. We estimate that this year's collections will be approximately $1.7 billion, representing the largest amount collected in the history of the revenue program. In addition, and consistent with industry measurement approaches, we are continuing to reduce gross days revenue outstanding, accounts receivable greater than ninety days, and days to bill.

Earlier this year, VA received recognition for its innovative and aggressive implementation of improved business processes from the National Automated Clearinghouse Association (NACHA), which represents over 12,000 financial institutions. NACHA awarded VA the 2004 Kevin O'Brian Automated Clearing House Quality Award for its e-payments system – a system that makes possible electronic receipt of remittance advices and payments.

Information Technology

We have made considerable improvement in operating processes and systems, migrating from a labor-intensive manual process to automated billing

and collection activities. We have developed automated utilities to support pre-registration and insurance verification and procured claims analyzer software to expedite clinical review of medical claims prior to submission to third-party payers. In addition, we have implemented electronic claims generation capabilities for transmittal of claims to third-party health insurance companies and activated a first-party lockbox to automatically apply payments from veterans to their outstanding co-payment charges. The automation of this process has simplified the process for veterans, significantly reduced processing time, and freed facility staff to concentrate on follow-up of insurance claims.

Enhancements and changes to the Veterans Health Information Systems and Technology Architecture (VistA) system have simplified many of the manual processes once utilized. We are currently procuring a commercial-off-the-shelf (COTS) Patient Financial Services System (PFSS) that is intended to replace the VistA Integrated Billing and Accounts Receivable packages. This system, coupled with several of the ongoing revenue action plan objectives, will provide VA with a state-of-the-art software solution that expedites the billing and collection process by enabling the establishment of encounter-based patient accounts and the production of substantially more reliable industry-based reporting, analysis, and decision support capabilities. As we move forward with changes to the billing and collection modules within VistA, we will be in close coordination with Presidential Management Initiatives in Health Information Technology, as efforts are underway to develop and implement electronic health records, health data standards, and an integrated Federal Health Architecture.

Revenue Action Plan

Upon creation of the CBO, VHA initiated a comprehensive assessment of ongoing activities within the revenue program. This assessment focused on "industry best" practices and resulted in the identification of a series of objectives in addition to those originally included in the 2001 Revenue Improvement Plan.

The immediate improvement strategies include development of the Medical Care Collections Fund (MCCF) performance metrics, an expanded focus on contracting for collection of accounts receivable over 60 days, and utilization of available contract support encompassing collections, insurance identification and verification, and coding. Currently, over 70 contracts are being used throughout VHA. Many of these are structured to allow contractors to retain a percentage of collections, which minimizes operational costs. Another significant accomplishment was to expedite the development and implementation of Electronic Data Interchange (EDI) for third-party claims to meet Health Insurance Portability and Accountability Act (HIPAA) deadlines. The initial e-Claims

software is operational at all VA facilities, and as of May 2004, more than 10 million claims have been generated.

An important mid-term improvement in the Revenue Action Plan, targeted for completion this fall, is to complete the Medicare Remittance Advice (MRA) project. This project is designed to improve the quality of our many Medicare supplemental claims and accurately identify deductible and coinsurance amounts that Medicare supplemental insurers calculate to determine reimbursement to VA. This effort will also allow VA to more accurately identify accounts receivable. Other mid-term strategies include:

- activation in September 2003 of an electronic insurance identification and verification process that has confirmed the existence of an estimated 105,000 health insurance policies;
- software enhancements implemented in October 2003 to enable receipt of electronic payments from insurers;
- continuing development of encounter-specific inpatient accounts (activated in March 2004), and further enhancements to the VistA clinical applications to collect data elements required for complete and accurate billing information (October 2004); and
- a further advanced redesign of our Health Eligibility Center database to provide enhanced eligibility and enrollment functionality, improve data quality, and expand data sharing capabilities. When the redesign is completed in October 2005, VHA will have a single enrollment database that will provide "register once" capability, support the delivery of consistent and reliable eligibility information across VHA, and enhance and further automate the availability of compensation and award data.

A major tactical initiative currently underway is the phased piloting of Consolidated Patient Account Centers (CPACs). Modeled after private industry as an effort to enhance revenue consolidation efforts throughout VA, the initiative is targeted for deployment in September 2005 and is designed to gain economies of scale by regionally consolidating key business functions. Once implemented, CPACs will serve to standardize business operations relating to "back office" functions.

PFSS

A major focus of our current long-term strategy is the implementation of an industry proven Patient Financial Services System (PFSS) that will yield dramatic

improvements in both the timeliness and quality of claims and collections.

A comprehensive reassessment and rigorous analysis of the PFSS project plan and associated timeframes has recently been completed to identify, in detail, the work and actions necessary to successfully blend the commercial PFSS system with VistA and our billing and collection work processes. A further outcome of the reassessment has resulted in changing the project from being matrix-managed to a single point of accountability-managed project under my direction and leadership. VA's Chief Information Officer, Mr. Robert McFarland, will provide additional oversight and monitoring to ensure the project stays on schedule. Because of the analysis and the corresponding adjustment in project timelines and leadership, we are confident that we will be able to successfully implement PFSS within the established timeframes. This very complex project is targeted for rollout at the first test site in VISN 10 (Cleveland) in October of 2005, with subsequent rollout to the remaining four VISN 10 test sites.

Refined cost estimates for the first pilot site in Cleveland are estimated to be $72.7M. A preliminary estimate for the remaining pilot sites is an additional $30M. We are working diligently to refine the preliminary estimate and to estimate enterprise-wide costs.

Due to its scope and complexity, this project is not without significant risk. VHA must make substantial changes across a large number of VistA applications to integrate with the commercial PFSS product. Therefore, we are using independent consultants to verify and validate our plans and to perform a thorough risk analysis. We are also incorporating lessons learned from the CoreFLS project to improve the likelihood of successful outcomes in PFSS. We believe these actions will result in a successful demonstration project that we can subsequently implement throughout VHA.

Conclusion

Mr. Chairman, we have seen significant improvements both in collections and overall performance, and we are optimistic that with the continued implementation of the revenue action plan, VA collections will continue to improve. However, we also believe that we can accomplish much more. We must continue to improve our performance in prospectively identifying veterans with billable health insurance, training and educating staff, improving the association of service-connected disability to treatment, expanding clinical documentation, and accurately coding and timely billing for reimbursable

services. We must continue to monitor and implement industry best practices and further expand communication with payers. Vital to these many efforts is the continuing dedicated support of VA leadership, acceptance of responsibility, accountability, and the assignment of stringent performance measures and incentives. As we continue to improve in these areas, we will be serving the best interests of both the Department and the veterans we serve by increasing the resources we need to provide them the high-quality health care they deserve.

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

Testimony
The Department of Veterans Affairs
Patient Financial Services System (PFSS) Project

Before the
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Mr. Edward C. Davies (Ted), Managing Partner
Unisys U.S. Federal Government Group
Accompanied by Mr. Joseph Macies, Partner

July 21, 2004

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to address the subcommittee today on Unisys' role as the prime contractor for the Department of Veterans Affairs Patient Financial Services System (PFSS) project.

As you know, PFSS is a congressionally-mandated pilot in Veterans Integrated Service Network (VISN 10). Its objective is to obtain significant improvements in the timeliness and quality of billing and increase collections of first and third party claims by implementing industry proven, commercial off-the-shelf (COTS) financial billing and accounts receivable software in the Veterans Health Administration (VHA), and by integrating it with the VistA legacy environment.

We are confident that the software product chosen by Unisys in a fly-off between the most qualified COTS vendors will meet VHA's patient management and patient financial requirements. The Unisys team continues to be fully committed to the success of the PFSS Pilot at all levels. We understand the program's strategic importance and are committed to a partnership with the VA to ensure we achieve the results desired by both VA and Congress. We have also seen strong VA executive commitment to this program over the past 3 months and believe the program is "on track" for success.

My testimony today will cover the following topics:

- Achievements since the last hearing, March 17, 2004
- Key Milestones
- PFSS Program and Technical Solution
- Top Risks and High Level Mitigation Strategy
- What we need from Congress to be successful
- Success strategies

Achievements since the last hearing, March 17, 2004

At the March 17, 2004 hearing, I testified that Unisys and the VHA Office of Information (OI) teams had analyzed gaps between the current systems and the target future flows to identify barriers to success. At that time, Unisys stated that these issues were the focus of ongoing discussions among Unisys, CBO, OI and VISN 10. These discussions were supported by intensive requirements analysis and as a result, took a few months to complete. A significant accomplishment of the past few months is the completion of these discussions and the complete agreement by all parties on the required changes to VistA, as well as the approach, roles and responsibilities and schedule for pilot implementation. We have also made significant progress on other fronts.

The VA has identified a single senior executive, Mr. Ken Ruyle, Chief Business Officer, (CBO) as the single point of contact, having authority and responsibility to address all PFSS related issues. In short, Mr. Ruyle is "in charge". The Unisys Executive operating

as the single point of contact, authority and responsibility to address all PFSS related issues continues to be Mr. Joe Macies. Mr. Macies is a certified Unisys partner.

We have also developed two detailed, well-aligned plans that will guide our efforts going forward. Unisys developed the PFSS COTS implementation plan, while OI developed their plan for the required VistA legacy systems modifications and VistA Interface Engine (VIE) interface effort. The two plans were developed using the same planning methodology and approach to facilitate the definition and identification of interdependencies between Unisys and OI and to allow tracking of actual weekly progress against the plans. We have identified the resource levels and skills required to execute the plans.

Finally, we have completed several Analysis stage deliverables that positioned us to start the detailed design stage in early July 2004. The Analysis Stage deliverables include: Functional Integration Requirements, Functional Process Flows (old and new), System Configuration Requirements, Application Configuration requirements, Organizational Interfaces, and a Final Analysis Document.

We recognize that much work remains. Success will only occur if we all execute as planned. The work done to date gives us a clear map of what needs to be done, by whom, and when. The critical path clearly shows the dependencies between Unisys and OI. Now what remains is for all of us to execute the plan.

Key Milestones

A critical aspect to the successful execution of the two plans is the detailed identification of dependencies or "touch points". There are dozens of touch points identified between the Unisys plan and the OI plan. Each touch point identifies who is responsible for sending and receiving the required data, due dates, and what tasks are impacted. This detailed level of integrated planning enables management of weekly progress, status and results. The weekly reporting will allow early corrective actions to be taken when issues arise. The high level Unisys milestones and dates are as follows:

Unisys Key Milestone	Due Date
1. IDX Design Specifications	July 14, 2004 - December 2004
2. Interfaces Specifications	July 2004 – November 2004
3. IDX System Build	August 2004 -May 30, 2005
4. Data Conversion Design	October 30, 2004
5. Interfaces Build	November 2004 – January 2005
6. IDX Functional Tests	November 2004 –April 2005
7. Roll Back Plan	March 30, 2005
8. Security Plan and Risk Assessment	July 2004 - April 2005
9. Integrated System Test	May 1 - 30, 2005
10. User Acceptance Test	June 1-30, 2005
11. Training Pilot	June 1-30, 2005
12. Simulation Test	July 1-August 30, 2005

13. System Activation Process	September 9 -October 28 – 2005
14. End User Training	October 1-October 28 2005
15. Cleveland Live	October 28, 2005

PFSS Program and Technical Solution

Unisys has conducted a comprehensive analysis of the current VHA revenue cycle systems and the target future business process flows. Unisys is confident that the COTS product, billing and patient management modules will meet the target future business needs and flows. However, as we have stated previously before this Subcommittee, there is much business transformation work to be done to align the VA revenue cycle organizations and business processes with the target future state supported by a COTS system. Change management, organizational alignment and new business processes are part of every major IT project, particularly if the project spans the entire enterprise. Both Unisys and the VHA recognize this need and are working on a business transformation strategy and plan for the pilot. Unisys will play a lead role in this transformation and is already applying resources to make this effort a success.

We recognize that the VistA legacy system changes present challenge. We believe that strong project management and dedicated VHA OI resources are absolutely critical to achieve success. OI has pledged to commit the necessary resources. We believe that OI will be successful as long as these resources are dedicated to this effort.

Top Risks and High Level Mitigation Strategy

The VA/Unisys team has identified several risk areas. Each risk was given a probability of occurring and the impact on the project if it occurred. Based on these criteria, the top risks and the associated mitigation strategy are identified below. For each risk/mitigation strategy, a team has been identified and a single point person for each will report status monthly.

1. The VA Standard **Messaging Architecture** is unproven with message types and volumes that may be driven through the system once PFSS is implemented. Mitigation- (OI lead) – Develop test scenarios with message types and volumes to prove capacity. Complete testing well before pilot completion.

2. A final **solution approach is not yet defined** in several application areas (Patient Treatment File, Charge Description Master (Service Master)), which could impact schedule and negatively impact the quality of the solution. Mitigation- (VISN 10 lead) – Finalize system specifications by August, and gain approval by the stakeholders.

3. A **single VA Point of Responsibility and Accountability** for the Project needs to be identified and empowered. Mitigation – Ken Ruyle has been identified and is now viewed by all as the project lead.

4. An on time **CPRS v27 final release is critical to project success.** Mitigation – (OI lead) CPRS schedules have been integrated into the plans. Resources are being identified. Resource adequacy and v27 status will be included in monthly PFSS project reviews.

5. Proper coordination of touch points with the **Austin Automation Center** is required.
Mitigation – (Unisys lead) Face to face planning sessions with AAC and FSC Points of Contact are planned and executive follow up will occur.

6. The ability to establish and execute **end to end systems testing** with all business partners (OI, AAC, FSC, 3rd Parties) due to lack of resources.
Mitigation – (All leads) High level executive commitment has been made to make systems and staff available for testing as schedules require.

7. **The Data Conversion Environment** must be available by November 1st, 2004.
Mitigation – Unisys will provide the Conversion Proposal, CBO will turn around a contract decision in August.

8. Adequate **Project Resources** from all business partners (OI, VHA, VISN 10, Unisys) are required throughout the pilot.
Mitigation – (All leads) Immediate actions have been put in place to engage 3rd party suppliers of M developers, VIE developers, and other project staff. Initial contact has been made with 3 potential suppliers.

What we need from Congress to be successful

This Subcommittee has been a strong proponent of PFSS since its inception. PFSS will require a transformation in the way the VA conducts patient financial management. The Department is ready for the change and in fact stakeholders and users are looking forward to the day when PFSS is fully implemented. However, change is never easy. It requires executive leadership and commitment. As a result, we believe that continued support and interest from this Subcommittee as the PFSS pilot moves forward will increase the likelihood of success. Congress has put forth a vision to improve collections. The Unisys team is committed to deliver on that vision. We welcome this Subcommittee's monitoring of our progress and will be happy to provide regular updates. We also appreciate your emphasis on ensuring that adequate VA resources, including personnel, are dedicated to the project, and that appropriate accountability and controls are in place to deliver needed results.

Success Strategies

We believe this project will be successful because we have included "best practice" approaches from the start. These include:

1. In the Analysis Stage, we assessed the gaps between the current system and the target future state flows to identify issues that would result in barriers to success. The key issues identified have been successfully resolved, both in terms of business process as well as the technical solution.

2. Users are involved in the day-to-day detail of designing the system. The users have a say in what will and what will not work in their environment. PFSS design will be user driven and user approved. We recognize the importance of early involvement and buy-in by both users within the Department, and with our ultimate customer – the veterans.

3. Users in VISN 10 will test the system. The system will be activated for the Pilot only if it passes the users acceptance test.

4. End User Training will be piloted during the user acceptance test activity. Lessons learned from the training pilot will be incorporated into the final end-user training plan.

5. Conversion of data has been started. Extensive analyses of conversion requirements and data cleanup, both manual and automated, has been performed.

6. Unisys did extensive work during the vendor runoff to determine the right COTS solutions in the VA environment.

7. Key risks have been identified and mitigation strategies are in place.

8. User training is part of the detail design and system build stages. This ensures that training incorporates not only what the users need to know but also incorporates the philosophy and rationale behind the new business process flows.

9. Information security and access are an integral part of the PFSS plan and are aligned with the VA Office of Cyber and Information Security (OCIS) policies and guidelines.

10. System Design and Build are aligned with the VA Enterprise Architecture policies and guidelines.

11. Network capacity for the Cleveland/system pilot has been analyzed to determine sufficient bandwidth.

12. PFSS is being modeled using Unisys 3D Visible Enterprise tools to capture the target future state design and provide a visual 3D model. This model will allow traceability by linking the business strategy and the information technology that supports PFSS and will ease rollout to the rest of VISN 10 and eventually nationwide.

13. Unisys has designed and presented a comprehensive business transformation strategy that will ensure the organizational and cultural changes that must accompany implementation of PFSS are accomplished.

Conclusion

Mr. Chairman, in my testimony I have outlined the progress made since the hearing of March 17, 2004. Although there was some delay while we examined alternative approaches for integration with VistA, we have made significant progress.

We know what needs to be done. We have a plan, agreed upon by all stakeholders, that shows who will execute it and how and when it will get done. We have touch points that show the dependencies between Unisys and OI allowing us to measure progress, status and results. We have a single VA executive responsible and accountable for PFSS.

Mr. Chairman, we have the right solution. We have universal buy-in, a documented and agreed to timeline, interdependencies and touch points, and a detailed work plan. We will have success if we all execute. We are eager and fully prepared to implement PFSS. Thank you for the opportunity to provide my comments to the subcommittee today. I look forward to your questions and comments.

Statement of

William D. Kirsh DO, MPH

Chief Executive Officer

eAppeals LLC

Miami Beach, Florida

Before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

House of Representatives

July 21, 2004

Chairman Buyer, Ranking Member Hooley and Members of the Subcommittee, let me thank you for allowing me the opportunity to appear before you today to discuss a proven technology which will increase the VA's recovery of disputed and denied healthcare claims. My name is Dr. William Kirsh and I am the CEO of eAppeals, LLC, a Miami, Florida based company that has developed an automated process for appealing disputed healthcare claims through a proprietary, patent-pending software solution. I am pleased to be here to discuss the progress that we have made thus far using this solution and to give you some background on eAppeals, the automated system we have developed.

eAppeals LLC is the only company to have created, commercialized and standardized an electronic system to process post-adjudicated disputed healthcare claims -- a process that has traditionally been done manually. In the $1.5 trillion commercial healthcare industry, nearly one third of all claims are legally appealable, consequently tying up enormous labor and capital costs. eAppeals can process over 1.2 million transactions in a 24 hour period while a labor-based method can process up to 15 claims per person per day. This manual process results in billions of disputable healthcare claims never being appealed. eAppeals' software solution enables healthcare systems to increase their cash flow by collecting receivables that are either aging on their books or are written off. The system is successful because the hospital (or their outside collections contractor) do not have the resources to process the large volume of disputable receivables or to handle the complicated procedures involved in the formal dispute resolution process. eAppeals processes the largest number of disputed healthcare claims and offers the only automated system. eAppeals has proven that it can process disputed healthcare appeals quicker, resulting in faster resolution at a fraction of the total net cost of the manual appeals process.

So far this year eAppeals has processed over $100 million of combined government and commercial healthcare appeals. The national average for recovery for claims over 365 days old is less than 5%; eAppeals has averaged a 12% plus recovery rate for disputed claims in aggregate of up to three years old. Most of these claims were written off by the facility prior to eAppeals processing them and no revenue was expected. Recovery of disputed claims is significantly higher for claims less than one year old.

There are two sides in the hospital reimbursement process: claim submission and claim appeal. If the hospital is not satisfied with the result of the claims submission adjudication process, it has the right under the laws of the state in which the hospital operates to appeal the decision. This is a legal process in which the rules are dictated by state and federal laws. Claim submission on the other hand is not a legal process. It is based on contractual terms between a hospital and the insurance company.

eAppeals automates the process for appealing disputed healthcare claims through its proprietary, patent-pending software solution. This solution simplifies the appeals process by replacing the inefficient labor intensive, paper based system in use today by hospitals with an integrated technology that combines a proprietary rules based software algorithm and an extensive demographic database of payer information. eAppeals electronically captures the previously submitted billing information from the hospitals accounting system, converts the medical claims data into an appeals format, applies applicable state and federal rules and transmits the information to third party payers dispute resolution units.

In November, 2002, eAppeals entered into a relationship with Electronic Data Systems (EDS) to process disputed healthcare claims for the VA's healthcare system. Since the commencement of this relationship, eAppeals and EDS have worked closely with the VA's Chief Business Office to

educate the various VISN's of the potential recovery for disputed claims and promote the EDS/eAppeals solution.

VISN 8 was the first VISN to adopt the EDS/eAppeals solution in January 2004. VISN 8 initially appealed disputed claims over two years old. It enjoyed significant financial rewards - payments of over $300,000 in only 4 months from a very small data file - with minimal operational expense. Currently, VISN 8 is considering processing younger open accounts through the eAppeals system; by processing younger disputed accounts a significantly higher percentage of recovery will occur. In addition to the dollars recovered, VISN 8 receives aggregated data that assists it in identifying and correcting deficiencies in the initial claim submission. Curing these defects at time of submission will minimize disputed claims and improve collections at first pass.

EDS/eAppeals has now been awarded contracts with VISN's 2, 5, 8, and 17. A quotation has been submitted to VISN 9, we are in active contract discussions with VISN10 and have made initial presentations to VISN's 15, 18, 21, 22, and 3. We are scheduled to make presentations to VISN 4 on July 27 and VISN 6 on July 22. To ease some of the contracting burden making the process more timely and efficient EDS is in the process submitting a proposal to be added to the General Services Administration Financial and Business Solutions Federal Supply Schedule. This will establish a Government contract with terms, conditions and pricing negotiated by GSA allowing the VA facilities to issue delivery orders for the covered services.

The VA will experience a continued growth in third party billings. The VA recognizes that in order to increase collections, it must adopt a systematic and electronic process of handling disputed claims. EDS/eAppeals offers the VA a cohesive system wide solution. In addition to a proven ability to recover dollars, the system allows the VA a common data stream and mechanism to track and monitor third party payers. This power of information will further help it negotiate improved health service rates, address specific healthcare service contract issues and refer particular matters to the VA General Counsel to collect on outstanding bills.

Mr. Chairman and Members of the Subcommittee, I thank you for your time and attention to this important issue, and look forward to working with the Subcommittee in any way possible to enhance the VA's effort to recover revenues from the appeal of disputed claims.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO DEPARTMENT OF VETERANS AFFAIRS

Fourth Hearing on VA's Third Party Collections

1. *You state that facility staffs were not effectively verifying and coordinating patient care with insurance carriers. Could you elaborate on the reasons?*

   A key factor in increasing Medical Care Collection Fund (MCCF) collections is for Veterans Health Administration (VHA) facility staff to have accurate demographic/personal information, including the veteran's address, telephone number, employment status, and health insurance coverage information. This information can be obtained through intake interviews (patient registration), when veterans come to the medical facility for care, and by using pre-registration software and telephonically obtaining the personal data prior to the veterans' scheduled medical treatments.

   Intake interviews are generally conducted at each VA medical facility by administrative staff. We have not been able to obtain a national listing of employees assigned to conduct intake interviews. However, we believe there are thousands of staff nationwide who may be performing intake duties. We found that administrative staffs were not conducting effective intake interviews based on limited testing described in our 2002 report (*Audit of the Medical Care Collection Fund Program, Report No. 01-00046-65, dated February 29, 2002*). During the audit, we attempted to contact 40 veterans whose VA administrative records indicated they did not have health insurance. In 20 of the 40 cases, we were unable to contact the veterans because their personal information was incorrect (e.g. incorrect telephone numbers). In addition, for 7 of these 40 cases the veterans' employment information was erroneous. We conducted additional tests of patient registration procedures by contacting 10 veterans who were on a medical facility's "Patients with Unidentified Insurance List." We found that 3 of the 10 veterans did have health insurance coverage.

   Our February 2002 audit also found that 25 of 135 (18 percent) VHA facilities were not using preregistration software. VHA has advised us that all medical facilities have installed preregistration software, and that as of August 4, 2004, the VA's Chief Business Office has begun monitoring all facilities. We have not reviewed the implementation of preregistration software by VA since our 2002 audit.

2. *You stated that medical record documentation of care was not adequate. Was this due largely to VA doctors not providing documentation? If so, should the VA invest in training doctors on adequate documentation for accurate coding?*

   Poor medical record documentation has contributed significantly to lost opportunities to bill for services. For example, our Combined Assessment Program (CAP) reviews conducted at 5 VA medical facilities this fiscal year identified lost opportunities to bill for care.

We reviewed the *"Reasons Not Billable Reports"* for a 6-month period ending in March 2004, and found that administrative staff identified 6,232 outpatient episodes of care or encounters totaling over $1.4 million that were not billable because the medical records did not contain adequate clinical documentation to support billing requirements. Seventy one percent (4,449/6,232) of the encounters involved care provided by resident physicians. Facility staff considered these encounters to be unbillable because the clinical documentation did not contain sufficient evidence of supervision by the attending staff physicians (e.g. progress note or countersignature).

On May 3, 2004, VHA published the revised Handbook on Resident Supervision, which defines the supervision and documentation requirements in all patient care settings (inpatients, outpatient, emergency room and extended care). VA has developed several training programs to educate employees and clinicians on procedures for billing, coding, and completing documentation. We have advised VA managers that they need to consistently evaluate the effectiveness of these educational programs. VA needs to also conduct regular internal audits of physicians' compliance with clinical documentation requirements in all patient care settings and take appropriate corrective action for non-compliance with documentation requirements.

In order to evaluate VHA facilities' compliance with the documentation requirements outlined in the revised handbook, my office plans to conduct a system-wide evaluation in fiscal year 2005. The national review will determine whether adequate controls are in place to ensure sufficient resident supervision, and will further review the causes for missed billing opportunities for care.

3. *What is the most current coding error rate that you have observed?*

Our last review of VA coding procedures found that about 50 percent of the 570 outpatient visits reviewed at 15 medical facilities contained coding errors *(Evaluation of Veterans Health Administration Coding Accuracy and Compliance Program, Report No. 01-00026-68, dated February 25, 2002).* We have not conducted a coding follow-up review.

4. *What is being done by the VA to pursue delinquent accounts?*

In May 2002, the Under Secretary for Health directed VHA facilities to refer accounts receivable over 60 days old to contract entities for collection. As of June 28, 2004, VHA reports that nearly all medical facilities are outsourcing follow-up activities associated with management of aged accounts receivable. The Department's Revenue Action Plan showed that the VA's Chief Business Office is responsible for monitoring this activity.

5. *Are there certain insurance companies that are consistently slow payers?*

   VHA MCCF managers at VA facilities have access to a *Reimbursable Insurance Trend Report* which shows each insurance carrier associated with their facility, the number of bills issued, the amount billed, and the amount collected. A collection percentage for each insurance carrier is also computed on that report. Facility managers can identify insurance carriers who may not be making appropriate payments on VA billings. While we have not conducted an audit of this issue, VA's June 2004 Revenue Action Plan includes reviews to identify specific insurance companies that are slow payers. VA plans to meet with these companies to determine ways to improve collections.

6. *Does the VA have a way of keeping track of how quickly the individual providers pay?*

   The *Reimbursable Insurance Trend Report* discussed in question 5 contains the date each bill was issued and the date payment was collected or the bill was otherwise closed.

Post Hearing Questions for VA
From The Honorable Chris Smith, Chairman
Committee on Veterans Affairs
U.S. House of Representatives
July 21, 2004

In relation to the Committee's July 21, 2004, hearing on VA Third Party Collections, attached are the Department's responses to the due diligence questions. To the extent the requested information is available, a detailed response is provided. In certain instances VA has provided responses secured directly from eAppeals LLC that are responsive to the questions provided to VA. In general, VA is satisfied that appropriate due diligence was performed on eAppeals.

1. **Under what legal entity is eAppeals operating? (eAppealSolutions.com, Inc. d/b/a eAppeals or eAppeals, LLC)**

   Response: According to the Florida Department of State public web cite, Division of Corporations, EAPPEALS LLC, EAPPEALSOLUTIONS, INC., E-APPEAL SOLUTIONS.COM, INC., and EAPPEALSOLUTIONS.COM, INC are all names that appear on the Corporate Name List. A statement on the bottom of the page also states that this is not the official record. The following information was obtained from Dun & Bradstreet:

   "This report contains a statement that the corporate details provided below may have been submitted by the management of the business and may not have been verified with the government agency which records such data."

   Registered Name: Eappealsolutions.com, Inc
   Corporation type: Profit
   Date incorporated: July 29, 1999
   State of incorporation: Florida
   Where filed: State Department/Corporation Division, Tallahassee, FL

   eAppeals response: The VA contracts with eAppeals LLC, a Delaware Limited Liability Company established on July 29, 2003. The VA contracts with eAppeals LLC as a prime contractor to provide electronic health care claim appeal services in VISNs 5 and 17, and is aware that eAppeals LLC serves as a subcontractor to Electronic Data Systems Corporation (EDS) to provide similar services in VISNs 8, 2 and 9. eAppeals LLC maintains its principal place of business at:

   1680 Michigan Ave.
   Suite 700
   Miami Beach, Florida 33139

2. **Who owns eAppeals? (name and ownership interest)**

   Response: The Florida Department of State, Division of Corporations, lists EAPPEALS LLC and the principal place of business at 1680 Michigan Ave., Suite 700, Miami, FL 33139. The following names are listed as managing members/managers at the place of business address: Kirsh, William; Kramer, Peter; Kane, Alice; Griffin, Steve; Riggs, Rory. Information regarding ownership interest in this business is not published on this document.

   eAppeals response: Dr. William Kirsh, Mr. Peter Kramer, and Mr. Jeffery King formed eAppeals LLC, and the Florida Department of State, Division of Corporations, lists the following individuals as managing members/managers:

   William Kirsh
   Peter Kramer
   Alice Kane
   Steve Griffin
   Rory Riggs

3. **Is eAppeals involved in any way in the legal proceedings of Scientia, ImClone, Sam Waksal or any of its owners?**

   eAppeals response: eAppeals LLC acquired all of the intellectual property of eAppealSolutions in September 2003. eAppealSolutions, founded in 1999, had received an investment of $2,500,000 from Scientia Health Group, Ltd. ("Scientia"), a healthcare investment fund in exchange for 52% of the company's stock. At the time of the investment in January 2002, Mr. Samuel Waksal, then Chief Executive Officer of ImClone Systems, Inc., was a principal in Scientia.

   Shortly after Mr. Waksal's criminal conduct came to light in late 2002, eAppealSolutions and its founders, both in their corporate and individual capacities, brought legal action against Scientia and its Board of Directors alleging various causes of action including breach of contract. The complaint also asserted various causes of action against Mr. Waksal, individually – including his failure to disclose to eAppealSolutions his ongoing criminal conduct.

   The formal legal court proceeding was dismissed on December 27, 2002, pursuant to a Settlement Agreement ("Agreement"). Under this Agreement, Scientia relinquished all right to its shares in eAppealSolutions in December 2002, and the legal relationship between Scientia and eAppealSolutions was extinguished via a Purchase Agreement and Release executed on September 9, 2003. All rights and interest in eAppealSolutions held by Scientia and, by association, Mr. Waksal, were terminated on this date.

   Accordingly, eAppeals LLC was at no time involved in the legal proceedings of ImClone, Sam Waksal, Scientia or any Scientia owners.

4. **How much of the $2,500,000 contributed by Scientia is being used to pay the lobbyists identified above?**

   eAppeals response: eAppeals LLC has received no financing from Scientia. Accordingly, no portion of any of eAppeals' expenses, including expenses to outside consultants, have been financed by Scientia.

5. **Do the lobbyists working for eAppeals know of Scientia's ownership interest and the relationship to ImClone and Sam Waksal?**

   eAppeals Response: Scientia maintains no ownership or financial interest in eAppeals LLC. All consultants engaged by eAppeals LLC are aware of Scientia's investment in eAppealSolutions and the legal proceedings described above.

6. **Do the members of Congress being lobbied know of Scientia's ownership interest relationship to ImClone and Sam Waksal?**

   Response: VA does not have information regarding Congressional knowledge of Scientia's investment in eAppealSolutions.

   eAppeals response: eAppeals LLC does not have information regarding Congressional knowledge of Scientia's investment in eAppealSolutions.

7. **How much does eAppeals currently owe Scientia? (loans, cumulative dividends)**

   eAppeals response: As a result of the Purchase Agreement and Release signed on September 9, 2003, eAppeals LLC has no financial obligation or debt to Scientia, Sam Waksal or any related party.

8. **What is eAppeals' current financial position? (copy of company's current financial statements)**

   eAppeals response: eAppeals LLC is a privately held company with sufficient capitalization for its operations.

9. **Does eAppeals employ as a senior member of management anyone with significant experience and expertise in business integration software?**

   eAppeals Response: Yes. The current senior management team has significant experience in the development and deployment of software technology. The management team has been involved in the application of software technology for health care services. Any limitations have been supplemented by the retention of software content experts including, but not limited to EDS.

10. **Does eAppeals still have a strategic technology agreement with Quovadx? If so, what does Quovadx provide the company? (business integration software, software support, data processing, other)**

    eAppeals response: eAppeals LLC neither has nor had any relationship or agreement with Quovadx.

11. Is eAppeals in any way involved in the SEC investigation of Quovadx?

eAppeals response: No.

12. How much does eAppeals currently owe Quovadx? Are any of the amounts owed past due?

eAppeals response: eAppeals LLC does not owe any monies to Quovadx. In 2002 eAppealSolutions contracted with Quovadx to develop a software integration platform but terminated the contract.

13. What does EDS provide eAppeals? (business integration software, software support, data processing, other)

eAppeals response: EDS and eAppeals entered into a teaming agreement to pursue VA contracts for processing appeals for disputed healthcare claims. EDS brings contract management expertise, knowledge of the VA systems, and extensive information technology expertise to the relationship. EDS and eAppeals jointly provide automated denied health care claims appeal processing to VA.

14. How much does eAppeals currently owe EDS? Are any of the amounts owed past due?

eAppeals response: There are no debts owed to EDS by eAppeals.

15. What do the 77 independent contractors provide eAppeals? (business integration software, software support, data processing, other)

eAppeals response: eAppealSolutions did contract with a number of independent sales agents to sell and distribute its software technology and services. eAppeals LLC continues this practices of using independent sales agents to sell and distribute its software, technology and services.

16. Is eAppeals involved in any lawsuits related to rights or use of the integrated business software?

eAppeals Response: There have never been any lawsuits against eAppeals (or its predecessor, eAppealSolutions) related to rights or use of the integrated business software.

17. Who developed the business integration software used by eAppeals? (name and summary of qualifications and expertise)

eAppeals response: The business integration software was designed and developed by its senior management team. Outside consultants were retained for software coding and programming.

18. Who owns the business integration software used by eAppeals? (name of individuals or company)

eAppeals response: eAppeals LLC owns all the intellectual property relating to the company's automated and standardized process for the electronic transmission of electronic healthcare appeals, including internet domain names, technology licenses, and proprietary software.

19. Who are the clients that eAppeals has successfully provided similar services? (name and contact number)

eAppeals Response: The following are representative clients receiving similar services to VA:

Frederick Memorial Hospital -- STEVE MURFIN 301 518 7303

Vitas, Inc. -- ROBIN JOHNSON 305 350 6041

Deaconess Hospital -- BETH LYNCH 406 657 4649

20. Is the software used by eAppeals HIPAA compliant?

Response: A product by itself cannot be compliant with the HIPAA Privacy Rule. However, a vendor must perform certain administrative and security safeguards to maintain compliance. VA ensures that the contract with a vendor binds the vendor to be compliant with the aspects of HIPAA that apply. The vendor then has the responsibility to follow the law. In addition, the vendor and VA should have in force a HIPAA Business Associate Agreement (BAA), as is required under the HIPAA legislation.

There currently are four aspects to Title II of HIPAA:

1. Privacy (in force as of April 14, 2003, and containing security provisions);
2. Electronic Transactions and Code Sets;
3. Security (to be in force by April 21, 2005); and
4. Identifiers.

To our knowledge, EDS/eAppeals is not conducting any of the HIPAA Electronic Transactions; therefore, that aspect would not apply. With regard to the Privacy and Security of the veterans' protected health information (PHI), EDS/eAppeals has the legal obligation, at a high level, to

(1) implement administrative, physical, and technical safeguards to protect and secure that data;
(2) use or disclose PHI in accordance with VA's minimum necessary policies and procedures;
(3) return or destroy the PHI gathered, created, received, or processed during the performance of the contract;
(4) notify VA should there be a breach in privacy or security; and
(5) take steps to remedy any breaches.

Specific to the contract in VISN 8, the VHA HIPAA Program Management Officer (PMO) has confirmed that VISN 8 does have a signed BAA with EDS/eAppeals. We conclude that EDS/eAppeals is aware of its obligations to be HIPAA-compliant. Additionally, the PMO has indicated that a national BAA would be the preferred course of action, rather than individual agreements with each VISN. The HIPAA PMO will contact EDS/eAppeals to pursue a national BAA.

eAppeals response: eAppeals, LLC is in compliance with all HIPAA regulations that apply to appeals processing and handling of Protected Health Information. The contracts with the VA have a business associate agreement incorporated and eAppeals, LLC has a business associate agreement in place with EDS.

21. **What security measures are used to prevent the unauthorized access or damage to VHA information systems?**

Response: According to the IT staff in VISN 8, the local Information Management staff runs the extract and places the data on the eAppeals system. Because this process is used, the security of VHA information systems is not compromised.

eAppeals response: In performance of the contract eAppeals employees do not have access to the VA information systems. Extraction of data from the VA information systems is performed by VA personnel.

22. **What security measures are used to prevent the unauthorized access or damage to Third Party Payer (TPP) information systems?**

eAppeals response: eAppeals employees have no access to Third Party Payer information systems. Any security measures to prevent unauthorized access or damage would be the responsibility of the Third Party Payer.

23. **How is VHA protected from the electronic filing of incorrect or false claims/appeals?**

eAppeals response: eAppeals handles only appeals for the VHA. These appeals are processed at the VHA's direction based on information provided to eAppeals by the VHA through EDS. VA extracts data on claims for appeals using selectable criteria to eliminate claims that are not suitable for appeal. Upon receipt of the claims to be appealed for the VHA, eAppeals processes the potential appeals through its own scrubbing software which also includes the payment and appeals criteria for the appeals. Any claims that are unsuitable for appeal are kicked out by the program and excluded from the appeals batches submitted to third party payors thereby protecting the VHA from submission of incorrect or false appeals.

24. **How are Third Party Payers (TPP's) protected from paying incorrect or fraudulent claims/appeals?**

eAppeals response: eAppeals ensures, through the process described above in Question 23, that only correct appeals are submitted to TPPs.

25. What kind and amount of insurance does eAppeals carry? (errors and omissions)

eAppeals response: eAppeals has $2,000,000 in General Liability insurance and Errors and Omission Insurance Coverage. This is a requirement of the subcontract with EDS.

eAppeals | A/R ASAP

July 26, 2004

VIA HAND DELIVERY AND FACSIMILE 202.273.6671

The Honorable Tim S. McClain
General Counsel
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. McClain:

In early July 2004, eAppeals LLC met with Members of the House Veterans Affairs Committee and their staff to provide a briefing on the success of the joint effort of eAppeals LLC ("eAppeals" or the "Company") and Electronic Data Systems Corporation ("EDS") in collecting dormant account receivables within the Department of Veterans Affairs ("Department" or "VA") healthcare system. On July 19, 2004, House Veterans Affairs Oversight and Investigations Subcommittee Chairman Steve Buyer invited eAppeals to accompany the Veterans Integrated Service Network ("VISN") 8 Chief Financial Officer ("CFO") Mr. Ken Ray to the Subcommittee's Fourth Hearing on VA's Third Party Collections. eAppeals accepted the Chairman's invitation to testify.

During the course of the July 21, 2004 hearing, Chairman Buyer instructed VA Assistant Secretary for Information and Technology Robert McFarland to "coordinate with [the] General Counsel of VA" prior to engaging in further expansion of the existing partnership between the Department and eAppeals. Chairman Buyer stated that he had been "given a document with regard from General Counsel" that unspecified "serious allegations" had arisen with respect to eAppeals' ownership, business relationships, and track record of performance. Following the Chairman's comment, we understand that there was an internal determination within the VA to "slow down" eAppeals' existing contract work since the "general counsel of the VA is investigating eAppeals." We can only speculate that the concerns were caused by an investor in a predecessor company. This correspondence will address that issue.

Both eAppeals and its teaming partner EDS view these unspecified allegations with the utmost seriousness. While we have not yet been given the opportunity to review the "document" that precipitated the Chairman's entirely unexpected comment, nor have we been apprised of the existence or intended nature of any VA General Counsel's inquiry, eAppeals and EDS desire to immediately address any questions regarding the Company and prevent any unwarranted interruption to our productive collaboration with the VA.

This letter outlines current and historical information regarding eAppeals' ownership, credentials, and business relationships, and further describes the considerable due diligence review conducted by the VA and EDS during the past two years. In addition, we request the

opportunity for eAppeals' senior leadership team and the EDS Project Manager for the VA relationship to meet with your office as soon as possible.

About eAppeals LLC

eAppeals is the first-known company to create and commercialize a standardized electronic system to process post-adjudicated disputed healthcare claims -- a process that has traditionally been done manually. In the $1.5 trillion healthcare industry, nearly one-third of all claims are appealable. eAppeals' technology solution is capable of processing over 1.2 million transactions in a 24 hour period, as compared to the more labor-based method that can process up to 15 claims per person per day. eAppeals' solution enables hospitals and healthcare providers to increase cash flow by collecting receivables that are either aging or were written off because of insufficient resources to cost-effectively process the large volume of disputable receivables or handle the complicated procedures involved in the formal dispute resolution process. eAppeals' system is now being used throughout the United States by a broad array of healthcare providers, hospitals, durable medical equipment companies, laboratories, and hospice entities.

Ownership Structure and Legacy History

eAppeals LLC was established on July 29, 2003 as a Delaware Limited Liability Company by Dr. William Kirsh, Mr. Peter Kramer, and Mr. Jeffery King. In September 2003, eAppeals acquired from eAppealSolutions, Inc. ("eAppealSolutions"), a Florida Corporation, all of its intellectual property, including internet domain names, technology licenses, and proprietary software. Messrs. Kirsh, Kramer and King had previously formed eAppealSolutions, Inc. in July 1999 for the purpose of creating an automated and standardized process for the electronic transmission of electronic healthcare appeals.

In March 2001, eAppealSolutions presented its business plan to Mr. Samuel Waksal, then Chief Executive Officer of ImClone Systems, Inc. and, at that time, a principal in Scientia Health Group, Ltd. ("Scientia"), a healthcare investment fund. In January 2002, Scientia completed a $2,500,000 investment in eAppealSolutions in exchange for 52% of the company's stock. At the time, Mr. Waksal headed one of the most innovative biotechnology companies in the country and was heralded as an innovator in cancer research. No one (including Wall Street, the FDA, Congress, or eAppealSolutions founders or management) was aware at the time that Mr. Waksal was engaged in criminal activity in violation of federal securities laws.

Mr. Waksal's criminal conduct became a matter of public record in late 2002, more than one year after Scientia's initial funding of eAppealSolutions. As a result of Mr. Waksal's legal and financial difficulties, Scientia breached both its fiduciary duties and funding obligations to eAppealSolutions. On November 22, 2002, eAppealSolutions and its founders, both in their corporate and individual capacities, brought legal action in the 11th Circuit of Florida seeking compensatory damages, as well as interest, costs and fees. The complaint asserted various causes of action against Scientia and Mr. Waksal, individually -- including his failure to disclose

to eAppealSolutions his ongoing criminal conduct. The cause of action was removed to Federal Court on December 5, 2002.

All parties to the action executed mutual releases, and entered into a Settlement Agreement on December 23, 2002. The formal legal court proceeding was dismissed on December 27, 2002. Pursuant to the Settlement Agreement, Scientia relinquished all right to its shares in eAppealSolutions in December 2002, and the legal relationship between Scientia and eAppealSolutions was extinguished via a Purchase Agreement and Release executed on September 9, 2003. All rights and interest in eAppealSolutions held by Scientia and, by association, Mr. Waksal, were terminated on this date. No Federal contracts were at any point signed with eAppealSolutions.

eAppeals subsequently acquired all of the intellectual property of eAppealSolutions. Neither Scientia nor Mr. Waksal participated in the formation or subsequent financing of eAppeals.

Unfortunately, we can only speculate that the source of the "serious allegations" expressed at the Subcommittee hearing regarding eAppeals arise from these well-documented investments received by eAppealSolutions, the legacy entity, and which were terminated by eAppealSolutions at its request through both judicial intervention and an ensuing settlement agreement. To be clear, eAppeals does not now, nor has it ever had, any business relationship with Samuel Waksal, Scientia Health Group Ltd. or any of its shareholders. Moreover, only eAppeals is a subcontractor to EDS as well as a prime contractor to the VA.

EDS and VA Due Dilligence

Beginning in November 2002, both EDS and the VA began a due diligence review of eAppealSolutions -- a process that transitioned with the change in asset ownership to a review of eAppeals. As eAppeals proceeded to develop a teaming relationship with EDS, and later contractual relationships with the VA, the Company was vetted by both EDS and the VA's Chief Business Office. These reviews included:

(1) Site visits in May 2003 by VISN 5 & 17 CFO's to the company's private sector customers to review its track record of performance and customer satisfaction;

(2) EDS' submission of eAppeals' private-sector customer references to the Chief Business Office;

(3) A May 2004 site visit by the VA's Chief Business Office and the VISN 8 CFO to eAppeals processing operations in Miami, Florida;

(4) EDS discussions with investors in eAppeals and discussion of its findings with VA officials as recently as April 2004;

(5) EDS discussions with eAppeals' software developers prior to entering into the Teaming Agreement with eAppeals and the January 22, 2004 contract with VISN 8;

(6) Informational meeting between eAppeals, EDS and the VA General Counsel's office regarding the VISN 8 contract; and

(7) Multiple meetings and conference calls between eAppeals, EDS and senior representatives from the VA's Chief Business Office.

In consultation with the VA on the VISN 8 project, eAppeals and EDS developed business process flows which were subsequently reviewed by the VA. In addition, the VA, EDS and eAppeals established certain milestones including the submission of monthly status reports by EDS.

At each step of the due diligence process, eAppeals has shared and made available to both the VA and EDS all requested structural, financial, customer, and technical information and data. Any concerns with legacy investments initially made in eAppealSolutions can be quickly resolved by reference to the public record of that company's actions to terminate its relationship with Scientia as detailed above.

Relationship with VA

eAppeals and EDS take great pride in their work with the Department's Chief Business Office and individual VISNs to develop an effective automated process for resolution of the Department's disputed third-party health insurance claims.

eAppeals and EDS are presently contracting with the VA, and have worked closely with the Department to implement an effective solution to the daunting challenge of disputed claims processing within the VA Health Care System. For your reference, a copy of the July 21st prepared statement of Dr. William Kirsh, eAppeals CEO, regarding the Company's VA experience is enclosed.

The VA's response to eAppeals work has been exceedingly positive, not only during implementation meetings as reflected in correspondence between the VA and the Company, but also as evidenced in the Department's July 21st public testimony before the Subcommittee. Mr. Ken Ray, VISN 8 CFO, testified as to the success of the eAppeals/EDS technology solution as follows:

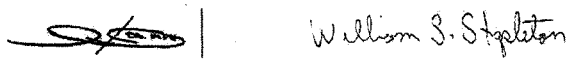
> "In summary, to date, we have been able to collect additional dollars through the use of this vendor. The Miami facility has found the vendor very easy to work with and communications have been excellent. Where problems have been encountered, *eAppeals* is there to help, weekly meetings are held and the disposition of all appealed claims are well documented."

The solution provided by eAppeals and EDS offers a cost-savings advantage that will ably assist the Department achieve key service and financial objectives, as evidenced by the track-record of success already underway in VISN 8. We wish to resolve whatever issues or

concerns -- and as we expect, whatever misunderstandings or misinformation -- may exist so that existing and future work may continue unhindered.

We look forward to further discussions with you. A member of the eAppeals/EDS team will be in touch with your office this week to arrange a meeting. Thank you in advance for your assistance in clarifying this matter.

Sincerely,



William D. Kirsh, DO, MPH
CEO
eAppeals LLC

William S. Stapleton
Project Manager
Electronic Data Systems Corporation.

cc: The Honorable Robert McFarland, Assistant Secretary for Information and Technology and Chief Information Officer, Department of Veterans Affairs
Mr. W. Kenneth Ruyle, Acting Chief Business Officer, Veterans Health Administration
E. Doug Bradshaw, Esq., Group I Assistant General Counsel, Department of Veterans Affairs
The Honorable Steve Buyer, Chairman, House Veterans Affairs Oversight and Investigations Subcommittee
The Honorable Darlene Hooley, Ranking Member, House Veterans Affairs Oversight and Investigations Subcommittee

Post Hearing Questions for Mr. Macies (UNISYS)
Hearing on the Department of Veterans' Affairs IT programs
July 21, 2004

Before the

House Committee on Veterans Affairs

Subcommittee on Oversight and Investigations 335 Cannon House Office Building

1. How will Unisys track all its milestones?

Unisys tracks all its milestones in the Project Management Plan (PMP) using Premavera's Team Play. All key detailed tasks required to complete the PFSS Pilot have been identified in the PMP and input in to Teamplay. This detailed plan includes tasks that are generally no more then 5 days in duration to assist with the tracking of performance. The tasks roll up to specified deliverables, which in turn rolls up to milestones. Unisys captures actual time and performance against plan on a weekly basis. Unisys and OI compare their respective plans for touch points (dependencies) on a weekly basis to make sure the plans are in sync and that the planned progress has been achieved. Tracking status on a weekly basis ensures early identification of any risks and enables quick implementation of corrective actions. Unisys and OI planners meet the first week of every month on site in Cleveland to review the accomplishments against plan in detail. The planners generate monthly performance reports for both the Unisys portion and the OI portion. The two individual plans are also combined for reporting. A monthly status report is generated for the VA senior executives and presented on the second Tuesday of each month. Changes to the plan baseline must be approved by Unisys, OI, CBO and VISN 10. Any major changes (schedule, cost, resources) must be escalated to Ken Ruyle for review and approval.

2. What happens if PFSS does not pass its end user tests?

During the current Design Phase (July –December), users will participate in developing the Use Cases that define the functionality and process flows of the "to be" PFSS. Once the Design of PFSS is completed and approved by the users, the system is built to those specifications. Unisys will then perform functional and integration testing. Once Unisys is satisfied that the system is performing to specifications and is integrated with the Legacy VistA system, the end user test will be conducted. The end users will test PFSS against the Use Cases they defined during the Design Phase. The end users will test for the completeness of

functionality, process flow, and integration. If PFSS does not pass any aspect of end user testing, the system will be corrected until it passes. PFSS will not be implemented until the system passes end user testing and acceptance.

3. **What delays and costs will be incurred if PFSS does not meet its milestones?**

Unisys is operating under a Firm Fixed Price contract. As a result, costs associated with Unisys not meeting our milestones would be absorbed by Unisys. OI costs associated with not meeting milestones would need to be absorbed by the VA. The project plan does include some flexibility to allow for unexpected delays while still meeting overall project milestones. The team is tracking progress against plan on a weekly basis. Deviations from the plan are evaluated and an impact analysis are performed. The impact analysis examines schedule, resources, and costs. The project status and any changes to the baseline plan are reported monthly to VA senior executives.

To avoid delays and additional cost, Unisys is continually evaluating risks and communicating any concerns directly to Ken Ruyle, PFSS Program Manager, who is responsible for all PFSS personnel, resources and performance. Unisys is working closely with Mr. Ruyle and the entire project team to identify and address all risks, including those for which both Unisys and VA are accountable.

4. **How confident is Unisys that the commercial off the shelf programs will meet the VA's needs in the future?**

Unisys is very confident that the commercial off the shelf software (COTS) will meet the VA's needs now and in the future. During the Analysis Phase Unisys along with VISN 10 developed the "as is" and "to be" functionality and flows for PFSS. This analysis and the demonstrations during COTS selection, validated that the IDX product very closely meets the VA needs. Furthermore the VA wants to adopt commercial best practices for the revenue cycle. As the third party requirements for submitting invoices change over time, the COTS product will continue to evolve to be viable in the commercial market place. The VA will continue to benefit from the investment in the COTS software that the vendor makes to keep up with industry best practices. One of the key design goals of the selected COTS product is to have industry standard HL-7 interfaces. By having an industry standard interface, the COTS product will not require changes as VistA evolves.