TO REVIEW THE PROGRESS OF THE DEPARTMENT OF VETERANS AFFAIRS REGARDING THE COLLECTION OF ITS MEDICAL CARE COLLECTION FUND (MCCF)

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

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TO REVIEW THE PROGRESS OF THE DEPARTMENT OF VETERANS AFFAIRS REGARDING THE COLLECTION OF ITS MEDICAL CARE COLLECTION FUND (MCCF)

WEDNESDAY, MAY 7, 2003

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

The subcommittee met, pursuant to call, at 2 p.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Boozman, Hooley, and Evans.

Also Present: Representative Beauprez.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. The Subcommittee on Oversight and Investigations of the House Veterans' Affairs Committee will come to order. We will be holding a hearing today, May 7, 2003, on the VA's Medical Care Collection Fund.

I am going to receive an update on the progress being made by the VA in improving its third-party collections, along with the recommendations of the GAO, along with recommendations from those in the private sector about different types of systems in operation in our society.

In the subcommittee's initial hearing in 1999 on the VA's collections process, we learned about its 5-year plan to obtain 10 percent of its funding from such collections. In 1997 Congress gave the VA the authority to retain any third-party collections recovered. Prior to this change in the law, the collections were returned to the U.S. Treasury. The VA acknowledged that prior to 1997 it had done a very poor job of collecting payments from insurance companies because there was no real incentive to do so.

On February 11, 2003, Secretary Principi presented the VA budget request for fiscal year 2004 and made the following observations with respect to its collections from insurance companies. The Secretary said, "We have got a lot of work ahead of us. We have got to identify veterans who have insurance. Sometimes we are not very good at getting that insurance information from veterans. We need to do better. We need to do a better job of installing software that enables us to better process, more accurately do coding and billing, which we are doing, and more training. There are so many different areas of this program that we need to improve."

If I were the director of a VA facility, I would be doing everything I could to collect these payments from the insurance companies. Why? Because each facility gets to keep the money it has collected. I guess I am baffled as to why every VA facility across the country is not being overly aggressive in its pursuit of third-party collections. It defies logic because whatever they collect they get to keep.

Granted, there are some fundamental problems in the system that limits the VA's ability to collect more dollars. In fact, these problems have been identified for years as the root cause of the failure of the system. They include missed multiple billing opportunities, huge billing backlogs, and inadequate follow-up on incredibly old accounts receivables.

These are longstanding problems and were repeatedly discussed in our previous hearings. Hopefully, today's hearing will give us some answers as to what is being done to correct these problems.

According to the IG, the VA had a loss in revenue of $500 million, approximately, for fiscal years 2000 and 2001. About 73 percent of this was due to a backlog in unbilled medical care and the lack of follow-up on delinquent bills. This is just unacceptable.

We held a second oversight hearing on this issue in September of 2001 to learn how the plan it had unveiled in our 1999 hearing was being implemented. Today, we hope to hear where the VA is in implementing its 2001 VA revenue cycle plan. Implementation of this plan, designed to improve core business processes, is moving rather slowly, with only 10 of the 24 proposed initiatives being completed.

I look forward to hearing from our witnesses today, and in particular, I want to thank the American Legion for participating in the hearing. Earlier this year, the Legion provided this committee with comments on ways to streamline and improve services to our Nation's veterans. I would like to share a portion of their comments as it relates to the VA's collection process.

In February, 2003, the Legion responded to my inquiry stating, "The American Legion recommends either providing enhanced information technology and training to improve VA's billing and collection capabilities or purchasing this service from the private sector. The American Legion is surprised VA is not authorized to hire certified coders. The Office of Personnel Management should reevaluate this decision."

I think we are sort of, from my own standpoint, sort of at a crossroads. We can do several things. We can go with the status quo and modify the hybrid system. We can enhance the hybrid system, meaning we do our collections in-house, do contracting at a local hospital level. Third, we could include for those outpatient facilities where we actually do contracting for medical services—we could include a contract for them to also do collections on accounts, and we strike that agreement in the contract. The fourth option would be that we move this core function out of the VA and into the private sector totally.

Those are the four options, really, that are in front of us. When the first thing they bring up to me is the protection of a job, that is a nonstarter for me. I want everybody to know that. There is too much money having been left on the table under the status quo.

So the purpose of this hearing today is that the VA is going to come forward and tell us what they have been doing about the implementation of the plan, and then we have the GAO. The nice thing we have done here today is we are going to have the VA and the GAO sitting at the same table. The reason we have done this is we are going to listen to testimony and create a little dialogue between the two of them. I want to find out whether or not the VA agrees with the audit and recommendations from the Government Accounting Office.

We are going to take some testimony from the private sector, because they have to depend upon these collections. It is their lifeblood. What has happened with the VA, those collections aren't the lifeblood of the health system of the VA. The lifeblood of the health system of the VA is the Committee on Appropriations, so why should they be motivated to do those collections when in fact the appropriators are always going to give them the money?

So that is the outline and purpose of this hearing today. I will now yield to the Ranking Member for any comments she may have.

[The prepared statement of Chairman Buyer appears on p. 35.]

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chairman.

This is my first hearing on MCCF. In fact, I had to ask what that meant. But I know this issue goes back a lot of years, and medical care cost funding is a very important part of the VA business initiative.

I also know since 1997, the first year VA was authorized to keep its collection funds, the VA has made some impressive gains. I know that had to provide some incentive for you to do that. I think that is good.

Then I think these gains were later enhanced by the implementation of the reasonable charges fee schedule. Progress is apparent in looking at this issue, but I think there is a lot of work to be done. That is one of the reasons we are here today.

The VA is developing strategies as part of their revenue cycle plan to increase collections: implementing metrics based in part on industry standards, developing improvements in technology, and centralizing revenue operations. I also know that this collection system, the VA collection system, is much more difficult than what we find in some of the other health care providers. We will hear some possible solutions on these issues today, and I am looking forward to that.

The VA appears to have come a long way. The Chief Business Office is headed in the right direction. The MCCF goal will become more focused once the Chief Business Office determines their universe of uncollected dollars and a more accurate level of collection costs. I am sure we will have another hearing before then to discuss their progress.

We must agree, Mr. Chairman, that there is strong evidence that the VA has improved its lot recently regarding third-party collections. We have many metrics and milestones to manage this program, but we are somewhat unclear as to how reliable our data is; or, for that matter, what rate of collections under current law

would represent success. I think it is important to define what success is. Hard data, I know, is sometimes hard to come by.

The Indian Health Service has been successful in billing and collecting Medicare Part A and B, and Medicaid funds. The VA can only collect Medicare supplemental. I am interested in hearing from the American Legion how similar or dissimilar these two systems are. I will follow up directly with the Indian Health Service in a study of their best practices.

In this subcommittee's last hearing on MCCF, we heard from two vendors with plans to help VA collect funds. My predecessor on this subcommittee asked some very tough questions. Many assertions and projections were made, but our question on collected revenues was not answered. A baseline could not be established. Success could not be determined.

I believe it is prudent, Mr. Chairman, to base our subcommittee recommendations on facts. We should not be afraid to look at the books to see if the numbers buttress the promises.

Mr. Chairman, MCCF activities are very much part of the VA's core business mission. It accounts for almost 8 percent of their anticipated revenues. When systemic performance is improving, we must allow them to continue to improve. We must tread cautiously when the business mission of the organization is so directly involved. When you are leading in a marathon and pulling away from a pack, Mr. Chairman, you don't stop at mile 23 to try on a new pair of running shoes without due cause.

I welcome our panelists from the VA and the GAO, as well as from the American Legion and various vendors, who will provide testimony today. Thank you, and I look forward to the testimony.

[The prepared statement of Congresswoman Hooley appears on p. 36.]

Mr. BUYER. I have run five marathons, so I like your analogy, except whoever led this pack got lost and I do not believe they are leading the pack.

I welcome the VA to the table.

We recognize the first panel, the Honorable Leo Mackay, Deputy Secretary of the Department of Veterans Affairs.

Dr. Mackay, who is accompanying you?

Dr. MACKAY. The chief business officer, Mr. Bob Perreault.

Mr. BUYER. Okay. Thank you.

And Ms. Bascetta, with the Government Accounting Office, director of the veterans health and benefit issues. You may introduce your staff.

Ms. BASCETTA. This is Mick Blair, assistant director.

Mr. BUYER. Thank you.

STATEMENTS OF HON. LEO S. MACKAY, JR., PH.D., DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: ROBERT A. PERREAULT, DIRECTOR, VETERANS HEALTH ADMINISTRATION BUSINESS OFFICE, DEPARTMENT OF VETERANS AFFAIRS; AND CYNTHIA BASCETTA, DIRECTOR, VETERANS' HEALTH AND BENEFITS ISSUES, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY: MICHAEL T. BLAIR, JR., ASSISTANT DIRECTOR OF HEALTH CARE, U.S. GENERAL ACCOUNTING OFFICE

Mr. BUYER. Mr. Assistant Secretary, we would like your testimony.

STATEMENT OF HON. LEO S. MACKAY, JR.

Dr. MACKAY. Thank you, Mr. Chairman. I am pleased to be here to share the progress and challenges of the future direction of the VA's revenue program. As I have mentioned, accompanying me is Robert Perreault, VHA's Chief Business Officer.

Mr. Chairman, our Department has made great strides in our medical care collection since Congress first gave us that collection authority in 1986, and even more so since the 1997 expansion of that authority. I do concede it took us significant time and resources to get up to speed in implementing reasonable charges, but the payoff has been worth it. This past March we collected a record $131.3 million. And I would also add that we have April figures in; that was another $131 million a month for us.

We look to be on track to collect an almost $1.6 billion this year, the largest amount in the history of the revenue program. We are proud of these results and the huge effort by VA employees that they represent.

Still, I will be the first to tell you that we have some unfinished business to address, many challenges ahead, and several exciting initiatives planned for the revenue program.

Mr. Chairman, development of our 2001 revenue improvement plan and (RIP) the Secretary's creation of the Chief Business Office within VHA have significantly contributed to revenue program improvements. The RIP identified 24 specific action items, as you have mentioned, for improving collections, which VHA has been diligently pursuing.

The Business Office subsequently developed an approach that consolidated the uncompleted RIP action items with several additional industry best practices. It took those best practice initiatives and assigned each to immediate mid-term and long-term improvement strategy classifications targeted for completion in June of this year, December 2003 and 2004 and beyond, respectively.

Mr. Chairman, prominent among the immediate strategies, and one of the first areas the Business Office has sought to address, is development and implementation of industry-based performance and operational metrics for both headquarters and field managers. Network and facility directors' performance standards already have been expanded for fiscal year 2003 to include revenue program-related measurements for amount of collections, gross days revenue outstanding, accounts receivable greater than 90 days, and days to bill.

Other immediate strategy objectives are to increase revenue program outsources, such as for collection of aging receivables, to implement an expanded program of regional centralization of revenue support activities, things like preregistration, insurance identification, accounts receivable management, and to require full implementation of electronic medical records effective October 2003.

The Business Office has numerous mid-level improvement strategies, which are described in my formal statement and I ask that the formal statement be entered into the record. However, I would like to note, two strategies here that are of particular importance.

First, we plan to implement a formal accounts receivable (AR) payment and denial management program at the network and facility levels to improve payer relationships, we are implementing a formal AR, Payment and Denial Management Program at the facility and VISN level, and will require establishment of audit-appeal business processes and claims development quality controls.

Next, we are on target for full implementation of the Medicare Remittance Advice (MRA) project by the end of this year. The MRA will expedite processing of Medicare supplemental claims and help VA to more accurately assess the amount of its accounts receivable.

Finally, a major focus of our long-term strategy is implementation of an industry-proven Patient Financial Services System, or PFFS. This together with planned improvements to our VistA applications, will vastly improve timeliness and quality of claims and ultimately increase collections.

In sum, we are working on program improvements to include VHA-wide responsibility, accountability, improved performance measures and incentives, education, structured organizational change, IT enhancement, and solutions, standardization and definition of performance-driven expectations that will provide real results. For example, results include the 32 percent growth in third-party revenue collections from 2001 to 2002 and also the doubling of total collections in just 2 years from fiscal year 2000 to fiscal year 2002.

I believe that we can achieve our goal of almost $1.6 billion in this fiscal year and our fiscal year 04 goal of $2.1 billion.

Mr. Chairman, that concludes my oral statement. Of course, both myself and Mr. Perreault will be pleased to answer any questions that you and the subcommittee members may have.

Mr. BUYER. Thank you. Your written testimony will be submitted for the Record. It is so ordered.

[The prepared statement of Dr. Mackay appears on p. 42.]

Mr. BUYER. Ms. Bascetta.

STATEMENT OF CYNTHIA BASCETTA

Ms. BASCETTA. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss VA's progress collecting third-party payments from veterans' private health insurers. As you know, these collections are VA's largest source of revenue to supplement its medical care appropriations. These payments are especially important because higher-income veterans without service-connected disabilities comprise a significant portion of the growth in demand for VA health care. Third-party collections are intended to help pay for the cost of their care.

My comments are based on the report we issued to you this January and some updating we did to prepare for this hearing.

I would like to make three points today:

First, while we are all certainly pleased to see collections increasing, much of the gain is attributable to improved implementation of reasonable charges, VA's new fee schedule.

Second, although the Chief Business Office is in place, operational problems have persisted for a long time and challenges to process improvement remain.

Finally, VA is still unable to measure how effectively its third-party collections process is supplementing the medical care fiscal appropriations. Last year, VA collected almost $690 million in insurance payments, and this year they should be commended for collecting almost $370 million so far. This is definitely going in the right direction, but it is still too early to call it an upward trend. Moreover, much of the gain reflects processing a higher volume of bills under the new fee schedule which was implemented in 1999. In other words, after being unprepared initially to bill reasonable charges, VA has been able to significantly improve its collections under this new fee schedule.

The higher collections, however, have occurred even with persistent operational problems like missed billing opportunities, backlogs, and inadequate pursuit of accounts receivable. So despite improvements resulting from the reasonable charges system, these kinds of operational problems are still limiting VA's potential to collect even more. Studies by the Inspector General and private consultants under contract to VA document that millions more remain uncollected.

VA's Chief Budget Office concurs that working on operational problems will in fact yield greater collections. VHA established the Budget Office to underscore the importance of revenue and eligibility issues, and the office has developed a new business approach that builds on the previous 24-step improvement plan.

Nevertheless, VHA is behind the plan's original schedule, and some items that will begin in 2004 as part of an automated financial system pilot are not scheduled for full implementation until 2005 at the earliest.

We support VA's attempt to achieve a state-of-the-art collection system. The Budget Office's initiatives could further enhance collections by identifying the root causes of problems in the processes, by providing a focused approach to addressing these causes, by establishing performance standards, and especially, by holding managers accountable for achieving those standards.

The tightening budget environments and the continuing growth in the lower-priority veterans' demands for care make it imperative that VA seek continuous improvement in its strategies to resolve its operational problems so it can maximize and sustain collections.

Our work and VA's continuing initiatives and commitment to improve collections highlight our basic message that VA hasn't collected all third-party payments to which it is entitled and needs to do much more. In fact, VA doesn't yet have an estimate of the total potential collections.

Mr. Chairman, we are interested not only in seeing collections rise, but also in measuring VA's progress against this potential

total. To determine the net effect of the collections process on VA's resources, we also need a complete measure of the cost of collections.

This concludes my prepared remarks. Mr. Blair and I would be happy to answer any questions you or the other subcommittee members might have.

[The prepared statement of Ms. Bascetta appears on p. 48.]

Mr. BUYER. Ms. Bascetta, if you were the CEO of a private enterprise in a health industry, profit or nonprofit, do you think you would be able to define what your universe is?

Ms. BASCETTA. I think it would probably be easier in the private sector actually to do that, because of the enrollment processes that occur in the private sector. VA is less able to necessarily identify all the other potential sources of insurance that veterans have. But doing so should be a top priority for them.

Mr. BUYER. Why wouldn't the VA make that a top priority, knowing what comes in the door and identifying the insurance and defining the universe? It is 3 years down the road and still we are talking about being unable to define the universe.

Ms. BASCETTA. That is a good question. I don't know. If I know that my collections are increasing but I don't know what the potential was that I could have collected, I really can't feel comfortable with the amount of progress.

Mr. BUYER. You and I are in agreement, because I keep hearing numbers. The numbers sound good, and yes, we are moving in the right direction; but I don't know—I don't have a baseline. I don't know what to rank it against.

I don't know how to grade it, Mr. Secretary, I don't at all, especially if we talk about, all right, great, that was 60 days, we go and we outsource it and we are going after it. But now we are only talking about that for which we know; we are not talking about that entire universe.

I am just trying to think, from a starting point, why don't you define that up front? When those veterans come in, why aren't we ask if they have insurance—tell me what happens.

Dr. MACKAY. One of the issues—and I would ask Mr. Perreault to comment further—one of the difficulties we have, Mr. Chairman, is that unlike in the private sector, where if a health care provider bills an insurance corporation and then the insurance corporation doesn't pay, oftentimes there is recourse back to the individual.

We don't follow that practice, so the incentive that veterans would have if that were our practice, that they would be in effect the payer of last resort, that incentive to reveal insurance information does not exist in our system, so many times veterans don't have the incentive to reveal insurance to us. In fact, they have a positive incentive not to reveal insurance to us. That is one issue.

We are also working with respect to the MRA process that I talked about, the Medicare remittances, where we would get a much more detailed and itemized account of what is available for us to charge in terms of Medicare and, what portion we can really go after. With MRA, we will have a much better idea of what our real accounts receivable are. That is part of that question of what the universe is.

Mr. BUYER. Hold that thought. If the number one reason you are citing that a veteran won't give their insurance is because they feel it might have some type of effect on them, why don't we stop and address that?

Dr. MACKAY. We are working inside the administration on a legislative proposal that would remedy that.

Mr. BUYER. What are you talking about?

Dr. MACKAY. We would ask that that information be revealed to us. Right now we have no authority to compel or to demand or in any way to get that information.

Mr. BUYER. So what is the stick? What is the hammer? How do you compel a veteran to disclose their insurance? Do you say you are not going to receive care? What are you proposing?

Dr. MACKAY. I am not proposing anything at this point, Mr. Chairman. Those things would have to be considered. We are dealing with veterans here. There would have to be some sort of inducement to do that.

Mr. BUYER. We are dealing with veterans that come in a much higher category, 7s and 8s. These are ones for whom—it is not the "entitlement" for them. So we are saying, you can come into the VA and you can utilize it, but in order to help us do this extra mission, it needs to be paid for. I am just curious.

Dr. MACKAY. Everything you say, Mr. Chairman, is correct, but we have a very delicate balance to be struck between our need for the insurance information, since it is important to us in defining this universe and in doing a better job of revenue collection, and the fact that this is a veterans' system.

We want to be solicitous of veterans. We want to cooperate with them in terms of their payment for the system. We want to strike a balance, Mr. Chairman.

Mr. BUYER. On page 212 of the IG audit of the VA consolidated financial statements for fiscal year 2002 and 2001, it cites a memo that was sent by Under Secretary Roswell to all VHA facilities, directing them to contract out all aged accounts receivables over 60 days old to a collection agency.

The memo further directs that all facilities report back on actions being taken to implement the directive to the network chief financial officer within 60 days. It is *now* one year later. Was that mission carried out?

Dr. MACKAY. Yes, sir, it was. Bob is much more knowledgeable about the details.

Mr. BUYER. Tell us what facilities have complied, please list the facilities that have not complied and why not, and how much revenue was generated by such action.

Mr. PERREAULT. We believe from the information we have that all facilities have complied. If not, we will provide that for the record. I will say for the 2002 contract support for aged receivables, we did collect over $60 million.

I might, Mr. Chairman——

Mr. BUYER. Can you share with me what types of contracts are out there? What kind of deal are you cutting with the private sector?

Mr. PERREAULT. A number of these contractors are contractors that are collection agencies who follow up with a range of different

approaches. The initial approach is, I think, less compelling to the people receiving the request as they move along in that strategy.

Mr. BUYER. Wait, that is not an answer. Is it 50 cents on the dollar, 40 cents on the dollar? What is being contracted out there? I don't know.

Mr. PERREAULT. There is a range of that. Typically, the contracts have a higher percentage again for the contractor the more aged the receivable is. It could be in the 20 percent range, it could be the 25 percent range; say 20 percent for 30 days, 25 percent for 60 days. Each contract——

Mr. BUYER. Sir, would you provide that for the committee?

Mr. PERREAULT. Sure.

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

Subject: May 7, 2003 hearing question, for the record.

Question: Mr. Buyer asked what types of revenue collection contracts VA is using and what return VA is getting back on the dollar via revenue collection contracts.

Response: VA has a variety of contracting mechanisms in place for aspects of the revenue program. Specific to follow-up of aged accounts receivable, VA medical centers are using a variety of contractors to follow-up on receivables once they reach 60 days delinquent. These vendors typically receive a percentage of collections from the amount recovered. Typically, the amount received is between 8 and 12 percent of the amount recovered. The amount varies by the age of the receivable. A recent field survey for third-party accounts receivable activities indicates that on average, VA pays $1 for every $13 collected. In FY 2002, we spent an estimated $4.6M for these services, resulting in approximately $60.3M in collections.

Mr. BUYER. I can better define "considerable progress," I can define that better if I know. So if you say we have done $60 million in collections, I don't know if that is good or not. It is hard for me—how do I know that? If you are saying that it is $60 million, yes, based off of what? If the total universe of that to be collected was $250 million or $300 million, $60 million in collections is not very good; and especially if after 60 days we have to turn to the private sector and, say, collect 50 cents on the dollar, sign me up. Is that kind of the right way for us to do business?

Sir, if you could provide that breakout for us, that would be helpful. I will let you finish your comment.

Mr. PERREAULT. I wanted to go back to your original question, sir, about defining the universe. Our challenge is far more complex than a community hospital. It is not just a matter of identifying whether or not the veteran has insurance. Yes, we can do a better job there, and we have a number of strategies in place to do that. But in addition to that, for every encounter of care, we must determine even whether portions of that particular encounter are billable or not. It is a far more complex process than any hospital ever is involved in in the billing of care, because no veteran can be billed for the care of their service-connected disability.

In a typical, a very typical case, a veteran might come in for a visit and see a primary care provider, have ancillary services, both diagnostic and laboratory services, may also see a specialist, may have a problem, with 5 to, in many cases, more than 10 problems on the problem list, and have many medications that are refilled during that visit.

We not only have to verify for each medication whether that is related to the veteran's service-connected disability, but we also need to verify for each problem that is being addressed whether that is related to the service-connected disability so we don't bill for that care. Nobody has to go through that kind of administrative process in a community hospital to bill.

Then—and I would just add a clarification to Ms. Hooley's opening statement—we do not have authority to collect anything from Medicare except in rare emergency-type circumstances. We do not have authority to collect Medicare Part B. So when we bill a case at 100 percent of charges and we have an unbilled amount out there stated at 100 percent of charges, it greatly overstates what the real collection amount could be, because for everybody who is covered by Medicare, the only potential collection we have is from the Medicare supplemental.

Mr. BUYER. We acknowledge your challenge on Medicare and the HMOs. We know that. I am trying to figure out some of the other parts.

I do have this last question for you. The Appropriations Committee is struggling with these issues also. Chairman Walsh put in last year's budget some demonstration projects. If you could tell me, Mr. Secretary, what is going on with them?

Dr. MACKAY. That resulted in the PFFS, the Patient Financial Services System. It is an integrated billing and accounts receivable system. What happened, as you relate, the Committee on Appropriations has directed that, but that became the occasion for a significant instance of business process redesign. Whereas we had wanted to be in a position to issue a contract in December of 2002, that has stretched to this month, where we have now completed market research, we have completed the initial steps of business process redesign, and we are now in a position this month, shortly, to issue a contract to a commercial provider.

Bob, do you have other details to add.

Mr. PERREAULT. When the Chief Business Office was established in May of last year, we also reassessed, and this contributed to the delay and the scope of what this project was, to ensure that we were meeting the intent of the request for the demonstration project.

As Dr. Mackay has mentioned, this project includes a very substantial business process redesign, beginning from eligibility determination to preregistration, insurance identification, insurance verification, the integration with the requirements of HIPAA, the development of a commercial accounts receivable and billing system such that it can be integrated with the VistA clinical information, which is absolutely critical to identify and develop claims.

That contract will be at least announced, I hope announced, within a month.

Mr. BUYER. For all four sites?

Mr. PERREAULT. This test is going to be in network 10. The contract will initially be put up as a pilot, but it is to be spread out over the entire network, which is network 10.

Mr. BUYER. All right.

Mr. PERREAULT. I will say that we have discussed this with Appropriations Committee staff. I think there is some concern that

this does not meet their intent. There have been follow-up discussions to determine if we need to consider another demonstration project. That is under consideration right now.

Mr. BUYER. I have been informed that in the 2003 appropriations bills it does state that no funds may be used to provide medical care to VA unless the veterans disclose their insurance. That was put in last year's appropriations bill.

Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chairman. I know you have some difficult issues to deal with. It is a system that is much more complex than most health care providers because of the service-related disability.

But a couple of things. First of all, in a follow-up to Mr. Buyer's question, I note the $60 million and that you spent $4½ million to collect $60 million. What I don't have, what would be very helpful to know would be how much was out there to be collected, with another column that indicates the entire universe and what is reasonably expected, knowing that you don't get 100 percent, knowing that there are some other issues that come up besides straight collection, to give us an idea of what that universe would be. If you can get us that, that would be really helpful.

Dr. MACKAY. We would be happy to provide it to you. One of the challenges that we have, Congresswoman, is that our data—its granularity and its fidelity to the underlying facts continues to evolve and to improve. We can give you the very best analysis that we have, the very best data that we have available.

For some of the reasons that we have talked about earlier, we are still going to be, in some sense, unclear about exactly where that is to the dollar; but we will give you, obviously, the very best information we have.

Ms. HOOLEY. I don't expect you to give it to the dollar, but I expect you to have a reasonable range.

Dr. MACKAY. Yes, we can do that.

(The information follows:)

Responses to Follow-up Information Requests
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
May 7, 2003

Hearing on VA's Progress on Third Party Collections (MCCF)

Ranking Member Darlene Hooley:

Request 1: The total amount that needs to be collected?

Response: The annual collection goal for FY 2003 is $1.575 billion for first and third party receivables.

Request 2: The total collection universe and the amounts normally collected for third party claims?

Response: The total collection universe for third party claims is:

Total Third Party Billing FYTD (April, 2003)	$1,647,785,088
Medicare Adjusted Billing Amount FYTD*	$ 725,025,438

*The Medicare Adjusted Billing amount is calculated using the following assumptions: (1) 70 percent of claims are for Medicare eligible patients and that for these veterans, VA collects approximately 20 percent of the claimed amount from their Medigap policies, and (2) 30 percent of claims are for patients under 65 and that for these veterans, minimal adjustments will be made by insurance carriers because VA is billing Reasonable Charges.

The historical amounts normally collected for third party claims since the inception of the program are:

FY	Collections (in millions)	FY	Collections (in millions)
1987	$ 15	1996	$ 500
1988	$ 94	1997	$ 454
1989	$129	1998	$ 457
1990	$138	1999	$ 420
1991	$264	2000	$ 394
1992	$379	2001	$ 540
1993	$441	2002	$ 690
1994	$511	2003	$ 804
1995	$528		

Ms. HOOLEY. Okay. Dr. Mackay or Mr. Perreault, how do you determine the VA costs to collect, the determination of costs to collect, and what ratio of collections is your ultimate goal?

Dr. MACKAY. This is a very technical issue because we have many, many differences with the commercial cost to collect than any sort of private sector provider would be more familiar with. I am going to let Bob enlighten you on this.

Mr. PERREAULT. I should also probably correct for the Record, "Doctor" is a title that I have not achieved yet, so "Mr." would be fine.

Ms. HOOLEY. Thank you.

Mr. PERREAULT. The cost-to-collect figure is based on our current level of accounting system. It is not structured like a community hospital. We do think that it is very fair in a manner to represent accurately our cost to collect as accurately as is possible given that data.

We have cost centers in which we include personnel costs, transportation costs, supply costs, contracting costs, and personnel costs for both field facility staff and central office and administrative staff and the networks that are costed to those cost centers. We aggregate those total costs and add them into the collections to determine the cost to collect.

One of the things we have done——

Mr. BUYER. Excuse me just a second. May I ask a question? Could the GAO validate the numbers the VA has just stated?

Ms. BASCETTA. No. At this time we are not able to do that.

Ms. HOOLEY. Go ahead.

Mr. PERREAULT. The community does not include a number of staffing and other associated costs with costs to collect that we know are in some way included in ours, so there is no way to compare apples and apples.

An example here is coders, for example. They are frequently costed in our cost to collect as part of the Business Office process in the VA. They are never included, at least according to the Hospital Accounts Receivable Analysis Report published by Zimmerman, which is a community benchmark standard for that kind of statistic.

There are other factors that are not readily comparable. We think that we will try to get there. One of the other key points is in the way we account. If we expect in the quarter to spend money, we have to obligate it up front. We actually put money for that cost on the table as a stated obligation because we can't even plan to spend it without accruing that obligation. That obligation becomes our cost as soon as it is obligated, whether or not it is spent in the quarter obligated. They don't count it in the cost of collection until they spend it.

Ms. HOOLEY. Let me ask you another question. With proper, aggressive management, could the VA have recouped all costs over 60 days old? Do you have any in-house success stories?

Dr. MACKAY. We have a number of systems in order to deal with delinquent collections. In addition to the contracting that was mentioned earlier, we have a debt management system, and we also participate, as the rest of the Federal Government does, in a De-

partment of Treasury program. So we have a full panoply of ways to try to collect that debt.

Some of it—my experience in both the private sector and the public sector is that there is such a thing as bad debt. You can never collect all of your receivables.

Ms. HOOLEY. I understand that. No one can.

Dr. MACKAY. Yes. Where exactly the frontier is of possibility, we are not there yet.

Ms. HOOLEY. Let me interrupt. I know private health care has to collect on debt, State revenue departments have to collect on debt, lots and lots of organizations and people have to collect on debts. It would be interesting to know what the universe is out there and what they usually can collect on debts. Maybe somebody else knows the answer to this question.

Mr. BUYER. Ms. Hooley, we have four or five votes. I apologize. You are going to have to hold fast. We are going to have to recess. Mr. Beauprez has joined the committee and has some pending legislation to address the matter. I ask unanimous consent that we allow him to make a 30-second statement before we go vote.

Without objection, so ordered. Mr. Beauprez.

OPENING STATEMENT OF HON. BOB BEAUPREZ, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. BEAUPREZ. I will be very brief. We will submit written testimony for the record.

Yesterday in the Health Subcommittee we marked up H.R. 1562, The Veterans' Health Care Cost Recovery Act, which I am a sponsor of. The bill speaks to exactly the issue that you are talking about. It will not necessarily be the magic wand, but it does authorize the Department of Veterans Affairs to receive full reimbursement for all people with insurance, except, of course, for service-connected disabled vets.

Part of the big problem is the VA hospitals are not identified as a primary care provider, and so basically insurance companies are blowing off the invoices when they are receiving them. This would make statutory the ability of the VA to enhance collections.

The estimate is that we may recapture hundreds of millions of dollars a year by this alone. So thank you for allowing me to mention that, and perhaps later, Doctor, you might want to respond.

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

Mr. BUYER. We will return. Mr. Beauprez, if you can share that legislation with the Secretary, we will discuss that legislation which we return.

The committee stands in recess.

[Recess.]

Mr. BUYER. The hearing will come back to order.

Right before we broke on the recess, Mr. Beauprez submitted some legislation. First, a quick cursory review.

Mr. Secretary, would you like to respond?

Dr. MACKAY. I regret Congressman Beauprez is not here. We are actually in complete agreement in support of this vital legislation. This would be particularly helpful to the Department as we deal

with the problem that we have been talking about today: the ability to have a wider universe of organizations, in this case PPOs, that we would be able to charge for work that we do for those who are signed up to those plans.

It would obviously increase the universe that you have talked about so well here in this hearing, it would be a real help to us, and it would get dollars into the Department to defray costs for real work that is actually performed in the service of veterans.

So this is good legislation, it is sound legislation, and I would like to thank Congressman Beauprez and this committee for its leadership in this bill, and for reporting this out.

Mr. BUYER. Dr. Mackay, have you read the GAO report?

Dr. MACKAY. Yes, sir, I have.

Mr. BUYER. Is there anything in the GAO report with which you disagree and would like to clarify for the Record?

Dr. MACKAY. Let me characterize my reaction to it, because a blanket statement like that—there may be some little point in it.

But what I would like to really complement the GAO on is that it is a tough but it is a fair critique, I believe, of where we are now. It recognizes some of the areas where we have actually implemented part of our revenue improvement plan. It recognizes the increase in the overall collections. It does point out that even though there is a good deal of this that is due to the increase in copay of the first party, there is a 32 percent increase third-party collections from 2001 to 2002, which is important to point out. We are making progress.

There is a very helpful chart that looks at the five major components of this revenue process that we have and details, maps into them the 24 steps of the revenue improvement plan. Obviously, this would need to be updated, because we now have a different approach to our revenue process improvement cycle; but it points to the comprehensiveness of the things that we have done. It points to also, I will admit, the incompleteness of the steps that we have started out on.

So I think it is, overall, to characterize it, it is a tough but it is a fair critique. We have made progress along all five—some progress along all five of these steps in the revenue process, but we have not completed our work. There are other things that we need to do and plan to do.

Mr. BUYER. What is the status of the preregistration of patients?

Dr. MACKAY. We have not closed out that item——

Mr. BUYER. Is it done for every facility?

Dr. MACKAY. No, sir.

Mr. BUYER. Why?

Dr. MACKAY. It is a step that we have not completed.

Mr. BUYER. Do you think it is important?

Dr. MACKAY. Yes.

Mr. BUYER. It is important?

Dr. MACKAY. It is important. It is a step that is part of our revenue cycle improvement, but to our knowledge it has not been closed out.

Mr. BUYER. Is it done in the private sector?

Dr. MACKAY. It is a necessary step. Yes, it is.

Mr. BUYER. You are right.

The challenge here is if we want to make government more efficient and effective, yes, sometimes, or often, we turn to the private sector because they have to be efficient in order to survive out there in that world.

So I think it is something that we should do as good stewards of the taxpayers' money is to make sure that if government is going to do something, make sure that it does so with sound business practices.

So that is where we are right now, Mr. Secretary, is that we are looking at this thing saying, is this a function that should remain with the VA or is this something that is too cumbersome for you to handle and we can get greater return by handing this out into the private sector?

I am just telling you, that is why—we are going to have some experts here in the private sector step forward. I think they would be stunned too.

Dr. MACKAY. But I would like to just point out, Mr. Chairman, with all respect, regardless—even if this was put over the fence to a private sector organization, they would have to do all the things that we are doing now. They would have to deal with the inherent clinical nature of the VistA system. They would have to deal with our coding problems and other issues. They would have to deal with the billing. They would have to have an integrated system. They would have to deal with a layered approach to accounts receivable; all of the things we are doing.

But there would be an additional complication, that in looking at the whole system, you would be going over—instead of melding in good private sector practices and commercial off-the-shelf technology like we are doing in PFFS, you would then have a public-private divide where you would be taking obviously the work—the clinical work is done inside the VA, and there would be some point at which you would go across an organizational boundary into the private sector.

There is also a very different set of laws and regulations and processes and procedures that governs our system. This is not private sector health care, as you know.

Mr. BUYER. I comprehend your statement. It is why when I said at the very beginning, I said we are sort of at this crossroads and we have four options from which we can choose. One of them, when the committee went to West Palm Beach and we search at one of the outpatient clinics. I was at the West Palm Beach Clinic, I am standing there listening to a nurse. The nurse is having to, I don't want to say argue, but it was a tough conversation between herself and a patient. The conversation was about really what I would call duplicative—it was multiplicative, even.

You have an individual who has a private doctor who prescribes certain drugs and he wants access to those drugs, so he is also in the VA system being seen by his doctor, and he is arguing about the drug that he wants out of the private sector, and he is angry because this doctor does not agree with his doctor. He does not understand why he can't get his drug. Now, if that isn't a mess.

At the same time, we look at that and go, how come we aren't collecting on it? Well, that outpatient facility, all of their work is shipped to that VA hospital. They are the ones who do the collec-

tions for that facility. That is why immediately I threw into this, when we award those contracts at those outpatient facilities, if you want to talk about your integration of care which you just mentioned, it is then we should be thinking about including the recovery when we give those contracts out to an outpatient clinic?

What are your thoughts?

Dr. MACKAY. My point in bringing up the fact is that there is not integration——

Mr. BUYER. Your thoughts on should we be giving the contracts out—is it worthy of our scope and review to consider whether or not they should be involved in the collections process, since they are intimately involved in the practice of care and delivering that care and coding and et cetera?

Dr. MACKAY. My opinion is that even though the care may be contracted out, this is such an integral business process—there is always a decision when you are managing any sort of organization, public or private, between what is core and what is noncore.

My judgment, my best judgment at this point, as a person who has managed in the public and the private sector, is that this is a core business process for VA, and it is a core business process because of the special characteristics of the veterans' health care system, because it is a public trust to handle the money and to handle the customer relations management, the private sector term. I want VA employees, public sector employees making that interface with the veteran.

I think if we apply properly business processes and procedures and metrics and properly incent our people, if we attack this fivefold revenue process that we have in the way that we have—I can't remember which one of the four of your choices this is, but essentially it is the system we have integrated with better business processes, with better management, and with selective insertions of technology and automation that will allow us to do a better job of income verification, a better job of documenting our care, better and smart uses of technology and software for claims analyzing. It is an incremental approach, Chairman Buyer.

Mr. BUYER. You get to argue out of both sides. You get to assert, I like the status quo, let us do our job, we are getting better. At the same time, you say, you know what, I get to pick and choose what our core functions are.

Now, there is nothing more a core function than actually "delivering that health care to the patient." Someone has made a decision that we can outsource that because it is being contracted. Yes?

Dr. MACKAY. Yes.

Mr. BUYER. So this is just a consequence. This is a consequence of the management of that health care. This is a consequent management system, the consequence of delivering that care. There is a cost, and we want to be able to receive it. Talk about core functions, we are beyond the core function argument.

I am not going to quibble with you, Mr. Secretary. I asked for your opinion and you gave it to me.

Dr. MACKAY. That is my opinion, sir.

Mr. BUYER. Right now, knowing the inherent weaknesses that you have, are there any areas which you recommend should be outsourced?

Dr. MACKAY. As we do a better job of firming up the processes and do business process redesign, I think we have some very good opportunities to look at what are commonly called "back office systems," the processes that other—when you look at HCA or some of the other health care organizations, the back office things they put in regional processing centers and that sometimes they outsource.

I think we could get to a place when we have good core redesigned processes that are in some sense—they won't be totally one-to-one compatible with the private sector, but much more compatible than they are today, and then I think we could very usefully do a public-private competition so we get competitively sourced the very best value for the American taxpayer. I think that is very possible. It is imminently doable. We would not be responsible if we didn't look at that as we evolve in this process.

Mr. BUYER. The GAO testified that the VA indicated in August of 2002 that 20 hospitals were still working on a step required to transmit bills to all payers. How many hospitals are still working on the electronic billing and how many have full functioning electronic billing?

Dr. MACKAY. I am going to let Mr. Perreault answer that.

Mr. PERREAULT. Thank you. Mr. Chairman, all hospitals currently have the capability for electronic billing. As of April this year, over 4 million claims had been submitted electronically.

There are continuing developments to allow for the submission of electronic pharmacy claims and dental claims that will occur later this year.

In Southern California, the Long Beach Hospital alone had more electronic claims than any other hospital in Southern California, as an example of our success. It is also complying with HIPAA.

Mr. BUYER. Can you identify a system or software solution that would identify all health plans in which a veteran is enrolled?

Mr. PERREAULT. Mr. Chairman, we do have in process the rollout of a systems improvement that will allow for electronic insurance identification verification. This system is also compliant with HIPAA in the way that this works.

Our claim will go to a clearinghouse, who then will compare against insurance companies that are typically serving the area where that veteran would likely have health insurance from that company. That will all be electronic under the HIPAA requirements by also November of this year.

Mr. BUYER. Gentlemen, I have been called away by leadership. I am going to ask Mr. Boozman to take the chair.

I ask unanimous consent that since the Ranking Member is not here, that our professional staff may inquire.

Hearing no objection, so ordered.

Mr. Boozman, will you please take the chair? I do plan to return.

Mr. BOOZMAN (presiding). I really do appreciate the Chairman calling the meeting. I think all of us would agree that our job is oversight. I think all of us would agree that there is money that is being left on the table in this area. That is the real concern.

My background is optometry. I have a lot of friends that are in the medical field. This is not a problem that is inherent to the VA. I understand that yours is more complex, but this is a problem that

many hospitals have struggled with for the last few years. There has been revenue that didn't make any difference.

But that is not true in the government anymore and it is not true in the private sector anymore, like I say. This is something that—as far as billing for co-pays, that has been a very common problem and many, many hospitals are grappling with that issue right now.

I guess what I would like to see is a list—break it down where you have a list of the hospitals as to what they are receiving as far as copay, and you can do that. You can be as complex as you want to, but you can get an indicator of who is doing a good job, by some criteria. You all can work that out.

I would like to really see a list of the hospitals that are doing a good job and seem to have a better handle on it than the others. You are going to have some on the high end; you are going to have some on the bottom.

To be honest, I have not talked to staff about this, but I would like to visit with the high-enders and the low-enders, and really encourage the low-enders to see how we can help them get the tools that they need to come up to where we want to come up, and also glean from the high-enders what they are doing different than the others.

Is that something that you can do?

Dr. MACKAY. Yes, sir, Congressman. As I talked about in my statement, we have a new and private sector-oriented set of metrics that we use and I personally review every month in a monthly performance review.

In fact, on my trip books when I go out into the field, whenever I go to a network headquarters or I go to a medical facility, I have the latest month's figures for that particular facility. It is always a point that I ask the medical center director how they are doing with their collections. We look at some of their activities year over year, and also in regard to norms and averages that have started to emerge as we have compiled more of this data.

I could not agree with you more about the importance of gleaning high performers and low performers. It is our job as management, as the central office, to make sure that learning that occurs in one part of our system is migrated to another. I think the Congress was very helpful to us and really exercised a good deal of leadership in its mandate for what became the PFSS project. That was an inquiry into commercial off-the-shelf system to see if we could get integrated billing and accounts receivable.

As I mentioned, and I don't know if this came out strongly enough, that has actually become an occasion for business process redesign for us. We have done a very diligent job of not just trying to get software off the shelf, but make the kind of improvements to our own internal software, the VistA system, some of our internal processes and procedures and the other things that would allow us to do a much better job of documenting the care that we give, determining what is service connected and nonservice connected.

We will also be making inquiries as to what degree that can be made more software-driven as opposed to manuallydriven. It has been an occasion to increase our own interim performance and our own internal—to really sharpen our performance metrics.

Bob, do you have a point?

Mr. PERREAULT. I would like to just make a comment about the collection of copays, Mr. Chairman. The VA does a very, I think, credible job in collecting copays. Our current rate of collections for those copays billed in total is around 92 percent to date through March 4, 2003. That is an improvement over 2002.

For first-party copays, we also take action to have those copays offset with either veterans' benefit payments or Treasury for delinquent debts; so the record of copay collections is very high.

Mr. BOOZMAN. Good.

Like I say, I would like to see the list. Then what would encourage me is if we could look at that list periodically and see some improvement.

The other thing is, the bill was mentioned earlier that was introduced, yet I think it would be an excellent idea if you all would really—if you saw something that we needed to amend that or whatever, to improve that, that would be of benefit in pursuing this.

Yes, ma'am.

Ms. CRAIG. Thank you, sir. I have a question for Mr. Perreault.

The VA expects to offset its fiscal year 04 health care budget with $2.1 million of MCCF funds. That is about 8 percent of the anticipated $27.5 million VHA medical care budget.

Since MCCF is used to offset the medical care budget, how can you guarantee that these collected funds will occur, and who will be accountable if the required amount of MCCF dollars are not collected for the fiscal year 04 budget cycle?

Mr. PERREAULT. That is a multipart question. The $2.1 billion estimate for collections in 2004 does include in the President's budget request the policy proposals for charging enrollment fees and some selected increases in copayments. The total associated with those policy proposals is approximately $330 million of the $2.1 billion.

We expect, as Dr. Mackay testified earlier, to collect the approximately $1.6 billion this year, and the difference we would attribute largely to the improvements that were involved in implementing for the PFFS project.

In terms of accountability, I will say that a great deal of effort has been focused on establishing and implementing new performance metrics, also as Dr. Mackay testified here earlier, and on that basis is how key managers will be held accountable.

Dr. MACKAY. I also want to say—because I know the Secretary feels this way, as well—the political leadership of the Department—and that ultimately is myself as the Chief Operating Officer and the Secretary as the President's Cabinet Member—are ultimately accountable for any and all operations of this Department.

So while a subsidiary medical facility directors and network directors would be held accountable for their portions of this plan, ultimate accountability rests with myself and ultimately with the Secretary. Let there be no confusion about that.

Ms. CRAIG. Thank you, sir.

Mr. BOOZMAN. I have a few questions of the GAO, and then we will move on.

In January of 2003, the GAO report stated that the VA missed billing opportunities due to unidentified care. In today's testimony,

you stated an increased number of patients with billable insurance was one reason for the increased billing. Was the increase in actual patients, identified patients?

Ms. BASCETTA. On the billable insurance question, there are two sources—two potentials for billable insurance: the enrollee population and the users. Our work was on the population using the system.

Mr. BOOZMAN. Okay. What is your gut feeling as far as—in your dealing with it, what are we missing here?

Ms. BASCETTA. It is an important question. As I have been listening to Dr. Mackay and Mr. Perreault talk, I have been trying to gather my own thoughts.

The first thing I would like to say is certainly the VA deserves a lot of credit for what they have been able to accomplish over the last year. Some of the things they have done, for example the progress they have made on the Medicare remittance advice, is very, very important.

My observation is it is too bad it didn't happen a long time ago; but this office that was not in place a long time ago, so perhaps it would have happened earlier under their leadership. Once done and once there was a commitment to do it, it seemed as though it was relatively straightforward. I don't want to oversimplify it, but they made it a priority and it happened.

Another observation that I have on issues like service connection and their difference from the private sector is that for a long time they had a commitment to have "one VA." It seems to me that the leadership in the commitment to make that happen is also critical; so that questions like whether something is service connected or not, with the computer technology that we have in this day and age, ought to be something they ought to be able to make a priority and have accomplished.

One of their real sources of pride is the computerized patient medical record, and incorporating the service connection component into that, although I am not a technology expert, ought to be something that would help to alleviate this problem quite a bit. Whereas in the private sector sometimes they struggle having to look for sources of information outside of their own control, under a "one VA,, this is information that they have in-house. It is a matter of VHA and VBA being able to talk to one another better, to be able to solve what is right now a pretty fundamental problem.

Mr. BOOZMAN. Does it make a difference—I know in the private sector the physician has a vested interest in coding things right, and up-coding—not up-coding in a manner that is unethical or dishonest, but in order for him to get paid, he codes how he is supposed to code.

Is that a problem in the VA in the sense that it doesn't really matter; the people that are actually doing the service are basically getting paid, you know, a flat rate?

Ms. BASCETTA. We have not looked at that specifically. I don't know that private sector doctors are necessarily any more careful about coding inherently.

Doctors are doctors. They are there to take care of the patient. I would hope that they would want the code to be appropriate for diagnostic reasons.

Mr. BOOZMAN. I think the other side of that is that the coding is so confusing that it is very easy when you are behind and—you are 2 hours behind and you have five people out in the hall, you are just trying to get out of there.

Ms. BASCETTA. It is clearly a challenge that is not unique to VA. The other point is that in the private sector, where the bottom line apparently matters much more, there are probably incentives of the managers who are working with those physicians to better ensure that they are properly trained and that they put enough priority on the importance of coding. But in that sense, VA shouldn't be different. They need those collections also.

And we see in the Chief Business Office that commitment to those sound business practices. And so they have administrative management and clinical staff and between the two of them there ought to be enough incentive to get the physicians to do a better job, if that is what is needed.

Mr. BOOZMAN. And again, I would encourage you, I think that really is something to look at, not as you say—physicians do try and do what is right, but in the sense of being behind and the fact that, you know, as somebody that used to code in Medicare things, it is very, very complex. And I really think you ought to look maybe at the difference in maybe the coding error rate in the private sector versus the VA. That is a little thing, but it is part of the whole equation.

Ms. BASCETTA. Actually, I do not have the numbers off the top of my head, but I believe the IG did look at coding. I think in February of 2002. I could check that for you.

(The information follows:)

The VA Inspector General issued its evaluation of coding accuracy on February 25, 2002. The review showed that VA needed to reduce its error rate. The IG found errors in 50 percent of outpatient visits, which was much higher than the 30 percent coding error rate reported by HCFA in 1996.

Mr. BOOZMAN. Good. Okay. Thank you.

Do you have anything sir?

Mr. EVANS. No.

Mr. BOOZMAN. Thank you all so much. I really do appreciate. I know that this is just a very difficult—it is just a tough situation. And the fact that with the VA system, it is—it is perhaps a little more difficult than the other. But again, I think it is something that is very, very important. And so we really do appreciate you all being here today.

Let me just do one more that they would like to get on the record. The GAO testified in 2001 about the vital importance of measuring net revenues to determine effectiveness of the program. What is the VA's cost to collect third-party revenue? After you determine the cost of collections, what is the net amount kept? And then, for instance, the welfare, West Palm VA collected $18 million last year. That is impressive, but of that $18 million, what is the net amount that actually would be—and I know you probably do not have that specific information, but do you have any comments about that? And then we can submit the question and get the answer later.

Dr. MACKAY. I would actually like to submit later—if the question is about that specific facility——

Mr. BOOZMAN. I think there is a question there too, it is just a gut feeling, you are spending a lot of money to collect money. What is the net that you are actually getting out of it? If you spend a dollar in collections, how much of that are you going to get to keep?

Dr. MACKAY. The best figures that we have, and I would tell you that because of the Medicare distortion, there is a lot of softness in these numbers, but we are at—in the monthly performance review last month, I saw we are at about 10 cents on the dollar, about 11 percent is our cost to collect. Which is out of step with the private sector, where I understand their cost of collections are down around 3 cents on the dollar.

Now, when we make adjustments for Medicare, because when you talk about our cost to collect, our accounts receivable are inflated by uncollectible Medicare charges which are part of the work that we do. Obviously, we think that figure is much less. Because of vagaries of calculating exactly what that uncollectible Medicare portion is, I do not have a lot of confidence in the figure. But we think that maybe half of that—about half of that 11 cents on the dollar is due to that Medicare distortion. So that we think our rate might be down around 5, 6 cents on the dollar. But our figures, our metrics are literally getting better, if not by the month, certainly by the quarter. We would be able happy to share with you how we get to those figures, so that you can see the assumptions that we use, and so that you understand where we are with that.

The important thing to figure out, though, is that we actually are improving year over year. Whereas, we think we are about 11 percent in year to date here in second quarter of 2003, we were at about 15, 16 percent in fiscal year 2002. So we are improving our cost to collect. Some of that is just constructing the metric, holding people accountable and looking at it. A lot of it is these incremental changes that add up. They are accretive. The process changes, the software changes. The efforts to hire more coders and train our own people via the web and via the EES system to be more attentive to this.

And to touch one more point, Congressman, that you brought up, is that before I was privileged by the President and the Senate to come to this job, I was on the board of a nationally recognized Children's Hospital, Cook Children's Hospital in Fort Worth. I will tell you, as a board member there, I was not concerned about the incentives that our doctors had to code. I was more concerned that the coding was accurate in connection with any sort of fraud charges. Because as you said, how you code, is how you get paid. And there is just an inbuilt incentive to code. And you have to be very, very attentive to make sure that insurance programs, particularly public insurance programs like the CHIPS program in Texas and Medicaid, which have very rigorous rules, are charged specifically and scrupulously what they have.

It is a different incentive structure and a different problem, but a similar problem in that the issue is coding, billing accounts receivable and insurance and the like. So there is similitude in kind, but the details are very, very different and the incentive structures are also very different.

Mr. BOOZMAN. What I see is, I think, Medicare has 110,000 pages of regulations. So the complexity is overwhelming. And you all are confident—the GAO is confident with the cost of collection?

Ms. BASCETTA. Are we confident with VA's numbers? No, we are not.

Actually, we have been working with them to try to better understand those numbers for a number of weeks now. And we have problems with both the way the numerator and the denominator is constructed to come up with that ratio. And I guess the best way to say it is to repeat Dr. Mackay's word that the numbers appear soft to us. Mr. Blair can give you a few specifics about our preliminary views on what some of the problems are with the cost to collect numbers.

Mr. BLAIR. The numbers we got from VA a couple of weeks ago are probably pretty good indicators, gross indicators if you will, of where they are going. But if you look at the individual components which make up the metric, for instance, billings, collections and operating expenses, there are some areas in each one of those, where I think they need to pay a little bit more attention, and we are working with them.

For instance, their total billings were misstated by $167 million. A minor error that they know they need to correct, but it is still not reflected properly on the information that has been provided to the committee.

The first part of collections is a situation where the Department is required to offset copayments with third-party billings that they receive from other insurance companies. That could tend to understate the amount of first-party collections.

Now, those dollars are actually zeroed out, so it does not even show up. As far as I understand it, it does not even show up in these numbers. So the first-party collection, had that not been the case, would have been a somewhat larger number.

Finally, when you look at the operating expense number, there are activities that go into those codes that Mr. Perreault was talking about. For instance, in the Health Revenue Center, there are some activities that we report on that they have identified, I think, 23,000 additional beneficiaries that had other health insurance. The cost to do that, as we were told, is not included in their operating costs.

And so there are some things like that that I think they need to work through to get them in better shape. And we have been working with them, at least in the last couple of weeks, in discussions with them.

I think we are comfortable in saying they are like gross indicators that are probably at this point.

Ms. BASCETTA. Let me just add that the importance of getting a good read on this cannot be overstated, because the ultimate objective is to get the best value for the taxpayer and to consider the most cost-effective options to perform this function.

Particularly through competitive sourcing, VA has to have a better handle on what their own costs are so they can compare them to other alternatives.

Dr. MACKAY. I would hasten to add, even though it sounds like a criticism, it is a critique that I share. Managers cannot manage

if they cannot measure and have confidence in the data. We are working with GAO, and we are constantly refining among ourselves to make sure that we know what we mean when we say cost to collect. That we understand what is in, what is out. I can only agree with GAO that good metrics and good data are of infinite value to a manager. We have every incentive to try to get those, and we are pursuing better data in company with GAO and also internally on our own.

Mr. BOOZMAN. Well, thank you all so much. I have all the confidence in the world that you are doing exactly that. And so it is important. It sounds like you all are working together.

But again thank you very much, and we will have the second panel now.

[Recess.]

Mr. BOOZMAN. Thank you all so much for coming.

I would like to recognize Mr. Joseph Glorioso, Director of Government Subscriber Relations, Digital Healthcare, Incorporated. Mr. Donald Blanding, Ms. Cathy Wiblemo—did I get that close—Deputy Director for Health Care, Veterans Affairs and Rehabilitation Division, the American Legion.

STATEMENTS OF DONALD N. BLANDING, HEALTHCARE INFORMATION TECHNOLOGY CONSULTANT; JOSEPH GLORIOSO, DIRECTOR GOVERNMENT SUBSCRIBER RELATIONS DIGITAL HEALTHCARE INC.; ACCOMPANIED BY GLEN HAROUFF, CHIEF TECHNOLOGY OFFICER DIGITAL HEALTHCARE INC.; AND CATHY C. WIBLEMO, DEPUTY DIRECTOR FOR HEALTH CARE VETERANS AFFAIRS AND REHABILITATION DIVISION, THE AMERICAN LEGION

Mr. BOOZMAN. Mr. Glorioso.

STATEMENT OF JOSEPH GLORIOSO

Mr. GLORIOSO. Thank you, Mr. Chairman, for this opportunity to address this subcommittee.

My name is Joseph Glorioso, the Director of Government Subscriber Relations at Digital Healthcare. Our company is the sole U.S. licensee of various patent claims on business processes and health care finance, including the core issue of today's hearing, the identification of primary insurance.

We know that VHS bills very little of its services to the private sector. The main problem that VHA will have in improving its billing to 30 percent of care is in finding the private insurance. There are 4,000 payers and 10 million eligibility changes per month in the United States.

The audited samples from the national cost analysis, that you will find in the testimony, show that large private hospitals with decades of billing experience bill the wrong payer 15 percent of the time, and that the Federal health plans pay when they are not primary.

There is no doubt about the soundness of our approach. Calling 4,000 payers to check insurance would get a better result than the current method but obviously 4,000 phone calls would take about 600 hours to complete. Our computers could search the whole market on 18,000 patients in a single second.

Economically, 600 hours at $15 an hour would amount to about $9,000 per admission. This on-line system can do the same work for a dollar. Our whole business purpose is to use the speed of the electron to resolve this issue on every claim faster than I can state the problem.

In the testimony, you will see that the Office of Management and Budget testified in favor of this method in the Senate in 1995 and that the work group on electronic data interchange, which included all the major payers and hospitals, said that this switchboard approach was the best means to fix the problem back in 1993.

You will also find, in the testimony, that the Senate in Oregon has a bill declaring an emergency to use our system on its Medicaid program.

If such a process were in place for the VHA, every claim would find its way to the proper primary payer without human effort. If VHA wants that result, it will need this patented process as a component of any billing system, whether it is in-house or outsourced.

We cannot guarantee exactly how much of VHA's budget will be saved. We can guarantee that every other source of coverage is tested before a claim is posted against the VA budget.

VHA medical center administrators, whom I have met with, have told me that they want the automation we are offering. These experts, and their peers in private hospitals, have told us that our method is a quantum leap over methods in use today. It seems to us that it is critical that the VHA notify the private provider community that this automated process is the inbox for its claims before those 58,000 trading partners expend irreplaceable dollars on HIPAA systems that cannot produce the same result.

We propose to tackle this problem in a couple of phases. First, we propose a nine-month pilot of this system to a large system of VHA facilities, and if the pilot improves billings, we propose to release the system to remaining VHA facilities in the ensuing quarter year.

As in thousands of military developments, it is necessary for Congress to provide the leadership to begin this project.

In this testimony, you will note the opinion of counsel that it is important for the committee to authorize the enforcement of HIPAA as written. HIPAA gives the VHA a statutory basis to find other coverage. And lest you hear differently elsewhere, the use of this automation would save private payers a lot of money too by cutting out their manual labor on COB.

Since this is a new system for VHA, the committee will be interested in the technical preparation that Digital Healthcare has made. With me today is our Chief Technology Officer, Glen Harouff. Prior to taking up responsibility for information technology at Digital Healthcare, Glen was a senior telecom engineer with MCI. He and our other colleagues in our IT staff have an average of 20 years experience in systems exactly like this one.

Our system uses the same mechanical process as the ATM, on-line stock market transactions, and long distance telephone systems and the track record of these is excellent. And as you will see in our testimony package, we are fully supported by Hewlett-Packard and MCI. There is nothing untried in our plan. We are ready to deploy this for the VHA. We built a prototype of this system in

1999, and IBM-owned Sequent Computer Systems verified that it would work.

Now, we are happy to answer any questions that you might have.

[The prepared statement of Mr. Glorioso appears on p. 64.]

Mr. BOOZMAN. Mr. Blanding.

STATEMENT OF DONALD L. BLANDING

Mr. BLANDING. Thank you, Mr. Chairman and distinguished members of the subcommittee, for providing me with the opportunity to appear before you today.

My name is Don Blanding, and I spent the last 18 years of my career in healthcare information technology. Nearly all of it as Executive Director for Information Services at Fairview in Minneapolis, Minnesota.

Mr. Chairman, I ask that the full text of my statement be printed in the record, and I will summarize my testimony.

Mr. BOOZMAN. Yes, without objection.

Mr. BLANDING. Fairview Health Services is a $1.5 billion not-for-profit health care company consisting of seven "care system." Each care system includes hospitals, clinics, home care and skilled nursing facilities. The largest includes Fairview University Medical Center, the teaching hospital of the University of Minnesota and surrounding facilities. There are two large metro care systems and four smaller ones in rural Minnesota.

Much of my time at Fairview focused on revenue cycle management. For our purposes, I will define revenue cycle management as all of those processes required to ensure successful and timely capture of revenues due the institution for patient care provided.

Revenues come from Medicare, Medicaid, private insurers, HMOs and the patients. In the next few minutes, I will highlight a few of those more critical steps in the revenue management cycle and, in some cases, how they might be addressed. My focus will be typical hospital visits. Nearly all of this effort takes place long before the patient bill or insurance claim is produced.

For example, preadmission and precertification takes place well before the patient presents at the facility. Accurate patient demographics in certifying that the patient is indeed insured for the upcoming procedure needs to be done very early in the process. Large institutions have a computerized list, referred to as master patient index, of names of patients and guarantors. Fairview's MPI consists of 3.3 million names. When a patient presents, it is understandably important that before adding a new entry to the MPI, that we are not creating a duplicate entry. Creating multiple entries for the same person has obvious clinical and financial ramifications. Likewise, assigning the presenting patient with the wrong MPI number is equally problematic.

Once admitted to the facility, it may be determined that additional procedures are medically necessary. Another certification process is now done before the procedure takes place to verify insurance coverage. During the hospital stay, the process of charge capture becomes important. Simply stated this amounts to making sure that the right supplies, pharmaceuticals, lab tests, et cetera are charged to the right patient account. In some hospitals, a dispensing machine not unlike a candy vending machine, is used for

supplies and some pharmaceuticals. The care giver must key in their identification and the patient's account number before the item is dispensed. This somewhat expensive approach effectively forces the caregiver to document how the items are used.

In a capitated or prospective payment environment, providers are paid based upon previously determined contracts that itemize fixed payment for specific procedures. Charge capture has no impact on the amount that a provider can expect to be paid. Payment is independent of the cost incurred by the provider. However, the cost information is every bit as important in tracking the expenses incurred in treating a given episode. Only then do we know the margin between the cost of providing the service and the payment received.

Once the patient leaves the hospital, several steps are required prior to preparing the patient bill. First the medical record or the chart must be completed at the nursing station. Then the physician dictates the discharge summary and signs the resulting transcribed report. Historically, the process often stopped here because physicians failed to sign these reports. In an effort to improve cash flow, we wait for physician signatures only in the most complicated cases, such as solid organ transplants at University Hospital.

Coding then takes place in the medical record department. Coders review the chart and with computer assisted logic assign ICD9 codes. The computers further analyze this and assign a diagnostic related group. There are several computer software packages available to assist in this process. Only now can a patient bill and insurance claim be produced. The Fairview benchmark for generating bills is six to ten days post discharge depending upon the institution and the complexity of the care.

Once the bill and claim are produced, the cycle continues by tracking by payer, the number of elapsed days prior to payment, which is referred to as accounts receivable days.

Bad debt is also monitored, and it is probably the most watched over statistic. Most bad debt may be defined here as amounts determined to be uncollectible due to a problem in any of the processes here. A bad debt rate of 1.75 percent of total revenues is an achievable goal.

Some summary points: First, there seems to be emphasis on collections after the patient bill or insurance claim is produced. This is too late. The focus needs to be on the process we discussed starting before the patient is admitted, before a bill is ever produced.

Secondly, there is a reference to "missed billing opportunities." Reference is made to one study where 5.5 percent of patient episodes that could have been billed were not billed. This couldn't happen in the private sector. That number would be zero.

Third, the GAO report discusses the use of professional fees, "pro fees." They are the provider's charges and the facilities fees that are the charge for the use of the "facility." In my experience, payers have very little interest in this distinction. Claims for facility fees are often simply ignored. The VA should monitor their success in this area.

Finally, this should not be looked on as an initiative to reduce the quality of health care available to veterans. Rather it is a se-

ries of process improvements and cultural changes to collect revenue for care provided.

Thank you.

[The prepared statement of Mr. Blanding appears on p. 74.]

Mr. BOOZMAN. Ms. Wiblemo.

STATEMENT OF CATHY C. WIBLEMO

Ms. WIBLEMO. On behalf of the American Legion, I would like to thank the subcommittee for the opportunity to speak today on the Medical Care Collection Fund. The American Legion is pleased with the recent progress made by the Department of Veterans Affairs in the administration of the MCCF. With the implementation of the Revenue Cycle Enhancement Plan in early fiscal year 2002, the Veterans Health Administration expects a dramatic increase in receipts and have doubled the amount they projected to receive in fiscal 2004 from $1.3 billion to $2.1 billion in anticipated money that will be plowed back into the system for veteran's health care for 2004 and is greatly need.

Having said that, the American Legion is adamantly opposed to the fact that MCCF collections are scored as an offset, rather than a supplement, to the discretionary medical care budget. We are always left wondering where the incentive is to keep increasing the collections. It seems that the more efficient they get, the more they are penalized.

While VA's accomplishments to date have been notable, there is a lot more room for improvement. VA is still experiencing problems—and there has been a lot of discussion on this—they are still experiencing considerable problems with coding errors. Well-trained coders are key to the success of a well-executed program, and in the case of third-party collections, absolutely critical. Another problem that VA continues to experience is the tremendous amount of turnover at the facility level of the coders. Once they are well-trained, they leave the VA for a higher paying positions in the private sector. The American Legion has suggested in the past that those positions be upgraded in order to maintain continuity.

To assist VA in their efforts to increase collections in a timely and efficient manner, the American Legion believes the MCCF system can benefit from agency models, such as Indian Health Service, that clearly exemplify the efficiencies gained through practical application.

Members of our staff visited IHS headquarters in Rockville, Maryland, and, subsequently, onto their operations in Albuquerque, New Mexico. The purpose of the visit was to find out the process they used to collect third-party revenue with emphasis on the Medicare component. We were particularly interested in how they became so successful.

IHS gave us a very—an overview of their process. Some of the key elements that they listed to maintain a successful program are: the first one was that there must be buy-in from the leadership and close monitoring of the process from the top. The need to train, train, train all of those involved. Everyone. And they, particularly, looked at coding and the coders and their training. Everyone must understand their role. And finally, again to reiterate, coders should

be certified and paid commensurate with the private sector for recruiting and retention purposes.

In conclusion, I would like to say that MCCF must become a substantial portion of VHA's operating revenue if VA is to provide timely access to quality care for veterans. While VA has made improvements, there is still room to do a better job. I would also like to add that we support the initiative in the President's fiscal year 2004 budget requiring HMOs and PPOs to consider VHA as a network provider or preferred supplier respectively.

That ends my statement, and I can answer any questions.

Mr. BOOZMAN. Thank you very much.

[The prepared statement of Ms. Wiblemo appears on p. 79.]

Mr. BOOZMAN. Mr. Blanding, if the VA focuses on the process and measurement, do you suggest that measurable standards be set locally, regionally or nationally.

Mr. BLANDING. Locally, absolutely. There are differences in large metro areas and small hospitals. I worked in both, and there is a difference in the variety of payers and variety of patients.

I would also look for what I call 80/20 areas, where 80 percent of the problem could be solved with 20 percent of the resources. There are a lot of those opportunities in Minneapolis. I can guarantee you that 90 percent of the payers are within three different organizations.

Mr. BOOZMAN. And I guess another question would be—we had some testimony about missed billing opportunities.

Mr. BLANDING. Yes.

Mr. BOOZMAN. Does this mean that care is provided and a patient bill or insurance claim is not produced?

Mr. BLANDING. That is my understanding of what was in the GAO report. There are 5.5 percent of the patients presented, a bill wasn't produced at all. The GAO could probably better answer that than I, but that was my understanding.

Mr. BOOZMAN. Okay. Another question for either one of you all, or for all of you all, where would you spend money, and how much money would you spend on the computer software and hardware for the VA?

Mr. BLANDING. I would go slowly in that area. Because I am concerned—my focus,—I was paid for doing stuff in IT, but the focus here for me is process, not technology.

Moreover, there has been some discussion of a new billing system. In my experience, accounts receivable days get worse for the first days after a new billing system, not better, until that system settles down.

So a year's pilot for a new billing system could result in some very misleading figures or statistics I would think.

Mr. GLORIOSO. With regard to expenditures, how much—your question was how much should one spend on that? And we look, obviously, at formula, because our company, because of what we do, cannot charge the way a lot of other people do in terms of charging on the basis of a percentage of amount recovered because in an actuality what we do is we look across all billing or all service rendered in real time, and actually can prevent money being spent or expenditures being made in the wrong area to begin with.

We look at more of a capitated rate to provide a full-service capability to the VHA, for example, and then for other health plans that we are talking with. But the concept here, for example, is that on a per member basis, and I will throw out a number here just as an example, if we charge a dollar per member per year or per month and billed on that basis, then what we would be doing is looking for that for all members all the time, for all care across all insurance plans on a continuous basis. So that what the VA would know is that they have looked at every other insurance coverage possible for that person whenever that person went for care anywhere.

So it is that kind of a system that would enable them to be sure of that level of integrity which is one of the key issues that is underlying all of this. Is the VHA doing enough to find that other insurance coverage that is out there? This would be the optimum approach to that.

Mr. BOOZMAN. How many clients do you all have?

Mr. GLORIOSO. Your question is a good one, and basically I would have to go back and tell you that in over the history of the company, we have gone through a transition from being what was a clearinghouse using an older method to the new method of full automation. And with the full automation, we have reached the point, now, where we have what I would call clients in queue, since the actual carrying out of this mission that I talked to you about is dependent on the enforcement of HIPAA which becomes a reality in October of this year when that will enable us to go across all 4,000 payers in the insurance arena based on the way their HIPAA regulation is designed.

So that in terms of the full automation that we are talking about, we have people waiting for that but have not yet begun to do that. So the answer to the question is no one is doing it completely yet. We have done it, we have tested it back in 1999 and at this point in time, we are ready to deploy it on the behalf of the VHA or any other entities, and, obviously, we need the time to ramp it up so there is a buildup time before October to enable this to happen.

Mr. BOOZMAN. Ms. Wiblemo, you mentioned the problem of the coders. As you mentioned, I think we all agree that is such an important thing because it is complex. Figuring out if you do this and this and this in the course of the examination, if you do three of those things, you get paid at a certain level. If you do a fourth, you get paid at another level. If they have a preexisting—if they are diabetic, you get paid at another level because they are diabetic.

You mentioned the discrepancy in the salary. Do you have any real figures as to what the VA is paying versus what somebody that is in the private sector?

Ms. WIBLEMO. I don't know that off the top of my head. I think some of the facilities, the positions, I don't know what they are graded specifically, GS–4, GS–5, GS–6, GS–7? I don't know. But I could get that.

Mr. BOOZMAN. Again, the Indian Health Care seems to be doing a good job in addressing some of these areas. How are they retaining their coders? Do you know?

Ms. WIBLEMO. Well, they have trained the coders that they have. They have certified coders, and they are paying them.

Mr. BOOZMAN. That is pretty basic. Mr. Evans.

Mr. EVANS. No questions.

Mr. BOOZMAN. Another question has come up concerning the coders. Right now, we do not have, basically, a requirement for certification within the VA system. Is that something that we need to look at doing?

Ms. WIBLEMO. Oh, I would think so, yes. As a matter of fact, I think we have testified that there is a vocational rehabilitation program within VA, and that could be maybe one of the avenues of sending people to school and training them, getting them positions there.

Mr. BLANDING. There are professional organizations that have certification processes for coders. I mean the stuff is available.

Mr. BOOZMAN. Right.

Mr. BLANDING. If they want to use it.

Mr. BOOZMAN. Very good. Well, again, thank you all so much for coming. And we certainly appreciate your testimony. On a very, very important, important subject. So if you do not have any more comments the meeting stands adjourned.

[The prepared statement of Congressman Evans appears on p. 36.]

[Whereupon, at 4:45 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN BUYER

Good afternoon. Today the Subcommittee will receive an update on the progress being made by the VA in improving its third party collections.

At the Subcommittee's initial hearing in 1999 on the VA's collections process we learned about its 5-year plan to obtain 10 percent of its funding from such collections. In 1997 Congress gave VA the authority to retain any third party collections recovered. Prior to this change in the law, collections were returned to the U.S. Treasury. The VA acknowledged that prior to 1997 it had done a very poor job of collecting payment from insurance companies because there was no real incentive to do so.

On February 11, 2003, Secretary Principi presented the VA Budget request for fiscal year 2004, and made the following observations with respect to its collections from insurance companies. He said, "We have got a lot of work ahead of us. We have got to identify veterans who have insurance. Sometimes we are not very good at getting that insurance information from veterans. We need to do better. We need to do a better job of installing software that enables us to better process, more accurately do coding and billing, which we are doing, and more training. There are so many different areas of this program that we need to improve."

You know if I were the Director of a VA facility I would be doing everything I could to collect these payments from insurance companies. Why? Because each facility gets to keep the money it has collected. I guess I'm baffled as to why every VA facility across the country isn't being overly aggressive in its pursuit of third party collections. It defies logic because whatever you collect you get to keep.

Granted there are some fundamental problems in the system that limit the VA's ability to collect more dollars. In fact, these problems have been identified for years as the root cause of the failure in the system. They include missed multiple billing opportunities, huge billing backlogs, and inadequate follow-up on incredibly old accounts receivable. These are longstanding problems and were repeatedly discussed in our previous hearings. Hopefully, today's hearing will give us some answers as to what is being done to correct these problems. According to the IG, the VA had a loss in revenue of $500 million for fiscal years 2000 and 2001. About 73 percent of this was due to a backlog of unbilled medical care, and the lack of follow-up on delinquent bills. This is simply unacceptable.

We held a second oversight hearing on this issue in September of 2001 to learn how the plan it had unveiled at our 1999 hearing was being implemented.

Today, we hope to hear where the VA is in implementing its 2001 VA Revenue Cycle Plan. Implementation of this plan, designed to improve core business processes, is moving rather slowly with only 10 of the 24 proposed initiatives having been completed.

I look forward to hearing from our witnesses today. In particular, I want to thank the American Legion for participating in this hearing. Earlier this year the Legion provided me with its comments on ways to streamline and improve services to our nation's veterans. I would like to share a portion of their comments since it relates to VA's collection process. In February of 2003 the Legion stated: "The American Legion recommends either providing enhanced information technology and training to improve VA's billing and collection capabilities or purchasing this service from the private sector. The American Legion is surprised VA is not authorized to hire certified coders. The Office of Personnel Management should reevaluate this decision."

I look forward to their testimony as well as our other distinguished witnesses.

PREPARED STATEMENT OF HON. DARLENE HOOLEY

Thank you, Mr. Chairman.

Although this is my first MCCF hearing as Ranking Member, this issue goes back many years. Medical Care Cost Funding is a very important part of VA's business mission. Since 1997, the first year VA was authorized to keep its collection funds, the VA has made impressive gains. These gains were later enhanced by the implementation of the Reasonable Charges Fee Schedule. Progress is apparent, but there is much work yet to do.

The VA is developing strategies as part of their Revenue Cycle Plan to increase collections; implementing metrics based in part on industry standards; developing improvements in technology, and centralizing revenue operations. We will hear some possible solutions for these issues today, and I am anticipating positive notification as the Business Office attains each milestone in the Plan.

The VA appears to have come a long way. The Chief Business Office is headed in the right direction. The MCCF goal will become more focused once the Chief Business Office determines their universe of uncollected dollars, and a more accurate level of collection costs. I'm sure we will have another hearing before then to discuss their progress.

We must agree, Mr. Chairman, that there is strong evidence VA has improved its lot recently regarding third party collections. We have many metrics and milestones to manage this program, but we are somewhat unclear as to how reliable our data is or, for that matter, what rate of collections under current law, would represent success. Hard data is, well hard to come by.

The Indian Health Service has been successful in billing and collecting Medicare Part A and B, and Medicaid funds. The VA can only collect Medicare Part B. I am interested in hearing from the American Legion how similar or dissimilar these two systems are. I will follow up directly with the Indian Health Service in a study of their best practices.

In this Subcommittee's last hearing on MCCF, we heard from two vendors with plans to help VA collect funds. My predecessor on this subcommittee asked those vendors some tough post hearing questions regarding economic performance and cost ratios. Many assertions and projections were made but our question on collected revenues was not answered. A baseline could not be established—success could not be determined. I believe it is prudent, Mr. Chairman, to base our subcommittee recommendations on facts—we should not be afraid to look at the books to see if the numbers buttress promises.

Mr. Chairman, MCCF activities are very much part of the VA's core business mission—it accounts for almost eight percent of anticipated FY 2004 Health Care Revenues. When systemic performance is demonstrably improving, we must allow them to continue to improve. We must tread cautiously when the business mission of the organization is so directly involved. When you are leading in a marathon and pulling away from the pack, Mr. Chairman, you don't stop at mile #23 to try on a new pair of running shoes without due cause.

I welcome our panelists from the VA and GAO, as well as the representatives of the American Legion and the various vendors who will provide testimony today.

Thank you, Mr. Chairman; I look forward to the testimony, and I yield back.

PREPARED STATEMENT OF HON. LANE EVANS

Thank you, Mr. Chairman. Thank you Ranking Member Hooley.

VA is relying more and more on third-party collections as a source of the funds VA needs to provide veterans health care. The reported 32 percent increase in collections is very significant.

How much VA can collect through MCCF is an unknown. VA has not forecast the rate of return needed to claim success. Questions remain about the reliability of data. The cost of collections is difficult to determine.

Competitive sourcing enhancements to MCCF should be cautiously studied while the Chief Business Office continues to demonstrate progress. I am acutely aware of the differences between VA and private sector collections problems. Private sector solutions may not provide a ready remedy to VA's collections complexities. Yet, there may be some best practices elements that are transferable. We should examine these practices.

I am here to listen to the issues and solutions offered by our witnesses. I hope that they also will put veterans before collections.

I Thank you, Mr. Chairman. I yield back.

Prepared statement of Congressman Beauprez

MR. BEAUPREZ: Mr. Chairman, thank you for allowing me time today to speak about my bill HR 1562, the Veterans Health Care Cost Recovery Act. This bill strengthens the Department of Veteran's Affairs ability to collect reimbursements from third parties to recover costs of medical care provided to veterans. Authorizing the Department of Veterans Affairs to receive full reimbursements from people with insurance, with the exception of service- connected disabled vets, will overwhelmingly help bring down collection rates which are currently as low as 41%.

There is no better time than now to pass this extremely important legislation. It is no secret the dollars are spread extremely thin here in Washington. It only makes sense to help the VA collect payments it is owed. The solution is fixing the problems that already exist, not appropriating more money to the VA to compensate for the lack of collected reimbursements. This bill is important in helping the VA find ways to become more efficient so waiting lists can be shortened and continued and improved quality healthcare can prevail.

Veterans in my district in Colorado often ask me what I am doing to help the VA provide better healthcare to our nations veterans. HR 1562 may seem like a small step, but the effects of this bill are far reaching collecting hundreds of millions of dollars owed to the Department of Veterans Affairs. HR 1562 is part of a commitment I made to my constituents to streamline efficiencies in the Federal Government so their tax dollars are used in the most effective manner possible. This is a very important step for veterans and taxpayers alike.

Again, thank you Mr. Chairman for allowing me to speak today.

SUMMARY
H.R. 1562, THE VETERANS HEALTH CARE COST RECOVERY ACT OF 2003

H.R. 1562 would:

1. Strengthen VA's rights under law to collect third-party reimbursements from certain third parties for the costs VA incurs in providing health care to veterans and others covered by a private or public health plan.

2. Specifically authorize reimbursement for services provided by VA to persons enrolled in and/or receiving treatment from VA health care facilities by designating VA as a "preferred provider" for purposes of collections when a payer might be a managed care or preferred provider organization or other non-traditional payer. This segment of the health care industry also includes the managed care plans within the Federal Employee Health Benefits Plan.

3. Authorize VA to receive full reimbursement for services provided to all persons with insurance, with the exception of service-disabled veterans for health care provided related to their service connected conditions.

4. Correct serious deficiencies in VA's ability to recover costs of care provided to patients covered by other health plans, by requiring these health plans to reimburse VA for legitimate expenses associated with a covered beneficiary.
    - A number of payers and plans that fully cover veterans have either refused to reimburse VA or have legally been unable to do so. This bill would eliminate these types of barriers to reimbursements to the VA system.
    - The absence of a participating agreement or other contractual agreement would no longer serve as grounds for denying or reducing amounts the Department may collect from third party payers.
    - This principle is not new.
    - Since 1986, VA has had statutory authority to collect from traditional insurers such as Blue Cross-Blue Shield, Aetna, Mutual of Omaha and many others. These funds are used by VA to supplement appropriated funds to maintain high quality health care.

5. Increase the amount of money VA could collect by hundreds of millions of dollars each year – providing funds that are desperately needed to reduce the waiting lists and promote better use of all available health care resources.

I

108TH CONGRESS
1ST SESSION

H. R. 1562

To amend title 38, United States Code, to enhance the authority of the Department of Veterans Affairs to recover costs of medical care furnished to veterans and other persons by the Department from third parties that provide health insurance coverage to such veterans and other persons.

IN THE HOUSE OF REPRESENTATIVES

APRIL 2, 2003

Mr. BEAUPREZ (for himself, Mr. SMITH of New Jersey, Mr. EVANS, Mr. SIMMONS, and Mr. RODRIGUEZ) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to enhance the authority of the Department of Veterans Affairs to recover costs of medical care furnished to veterans and other persons by the Department from third parties that provide health insurance coverage to such veterans and other persons.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Health Care Cost Recovery Act of 2003".

SEC. 2. AUTHORITY FOR DEPARTMENT OF VETERANS AFFAIRS TO RECOVER MEDICAL COSTS FROM THIRD-PARTY PROVIDERS AS IF IT IS A PREFERRED PROVIDER ORGANIZATION.

Section 1729(f) of title 38, United States Code, is amended by adding at the end the following new sentence: "The absence of a participation agreement or other contractual arrangement entered into by the Secretary with a person obligated to provide, or to pay, the expenses of health services under a health-plan contract or with a third party that is a preferred provider organization may not be used or operate to prevent, or reduce the amount of, any such recovery or collection by the United States.".

SEC. 3. RECOVERY OF COSTS OF HEALTH CARE AND SERVICES PROVIDED TO PERSONS OTHER THAN VETERANS.

(a) COST RECOVERY.—Section 1729 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(j)(1) Whenever the Secretary furnishes care and services to a person other than a veteran, the United States shall have the right to recover or collect charges for such care or services in the same manner, and to the same extent, as is provided under this section for care and services furnished to a veteran, except that for such purpose the terms 'health-plan contract' and 'third-party'

shall have the meanings set forth in paragraphs (2) and (3), respectively, of section 1725(f) of this title.

"(2) The amounts of charges under paragraph (1) shall be in such amounts as the Secretary may prescribe by regulation.".

(b) TECHNICAL AMENDMENTS.—Subsection (a)(2) of such section is amended—

(1) by inserting "or" at the end of subparagraph (C); and

(2) by striking subparagraphs (D) and (E) and inserting the following:

"(D) that is incurred by a veteran who is entitled to care (or payment of the expenses of care) under a health-plan contract, but, in the case of a veteran who has a service-connected disability, only with respect to care and services furnished before October 1, 2007.".

SEC. 4. EFFECTIVE DATE.

The amendments made by sections 2 and 3(a) shall apply only with respect to care and services furnished under chapter 17 of title 38, United States Code, on and after the date of the enactment of this Act.

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STATEMENT OF

THE HONORABLE LEO S. MACKAY, Jr., Ph.D.

DEPUTY SECRETARY

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MAY 7, 2003

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to share with you the progress, challenges, and future direction of the Department of Veterans Affairs (VA) revenue program. Accompanying me is Mr. Robert A. Perreault, VHA's Chief Business Officer.

As you know, Dr. Roswell established the Chief Business Office (CBO) within the Veterans Health Administration (VHA) not quite one year ago. The charge Secretary Principi and I issued to VHA and to the CBO 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 ensure achievement of the goals and expectations of the revenue program. Within the past year, the CBO has expanded the scope of our 2001 Revenue Improvement Plan by incorporating additional immediate, mid-range, and long-term improvements encompassing the broad range of business processes that impact VA revenue activities. The strategies being pursued include establishment of health care industry based performance and operational metrics, technology enhancements and integration of proven business approaches, including establishment of centralized revenue operation centers.

To provide some good news at the outset of my testimony, I am pleased to report that collections continue to increase and that during the month of March 2003, VA realized a record $131.3 million in collections. Collections through March now total $715 million, which is $228 million above last year's collection rate. We estimate that this year's collections will approximate $1.6 billion, representing, the largest amount collected in the history of the revenue program. In addition, and consistent with industry measurement approaches, we have continued to reduce gross days' revenue outstanding, accounts receivable greater than ninety days, and days to bill.

Background

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

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

Public Law 105-33, enacted in 1997, established the Medical Care Collections Fund (MCCF) and authorized VA to retain collections from health insurers and veteran's copayments at the local medical center. Prior to this law, these collections, less administrative costs, were returned to the Department of Treasury.

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

Public Law 106-117, enacted in 1999, authorized the Secretary of VA to set outpatient and medication copayments rates and to establish a maximum cap on medication copayments for a calendar year. This law also authorized the Secretary to establish extended care copayment amounts, a maximum monthly copayment cap and a process to determine an individual veteran's co-pay based on a veteran's available resources.

Information Technology

We have made considerable improvement in operating processes and systems through the years, migrating from a labor-intensive manual process to automated billing and collection activity. We 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 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 (VistA) have simplified many of the manual processes once utilized. However, as previously noted, much more needs to be done. 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 package. 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 substantially more reliable industry based reporting and analysis capabilities.

Performance Monitoring

As VA has embarked on its expanded revenue action plan, we have learned that "industry best" performance is built on a foundation of reliable registration, insurance identification and verification and pre-authorization processes. We know that those activities must be coupled with technological interfaces that optimize automated collection of treatment information and timely coding of all essential health care delivery information. As such, actions have been initiated, with the appropriate application of regulations, defining payment criteria and extending through the registration and eligibility determination process to denial and payer relationship management.

Fundamentally, to improve our revenue performance, we first had to know how we were doing. As previously noted, one of the first efforts initiated with the establishment of the CBO was the development of industry based performance and operational metrics for headquarters and field managers. The first iteration of the new performance standards was implemented at the beginning of FY 03 and included amount of collections, gross days revenue outstanding, accounts receivable greater than 90 days, and days to bill. In addition we have initiated the reporting of billed amounts, percentage of collections versus bills and cost to collect. Facilities have favorably responded to the new performance metrics and improvements have been noted in almost every category.

Revenue Improvement Plan

Upon creation of the CBO, management 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 additional objectives, in addition to those originally included the 2001 Revenue Improvement Plan. The current CBO revenue action plan has combined those objectives and classified immediate improvement strategies targeted for completion by June 2003. Mid-term strategies are to be completed by December 2003, and long-term strategies are scheduled for completion in 2004 and beyond.

The immediate improvement strategies included development of the 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, coding, etc. Currently, over 70 outsourcing contracts are being used. Many of these are structured to allow contractors to retain a percentage of collections, which minimizes operational costs. Additionally, among our immediate objectives the Health Revenue Center (HRC) in Topeka, KS was established to pilot regionalization of centralize revenue support activities. From July 2002 through March 2003 HRC activities yielded an additional $6.0 million in collections. Based on the results of the HRC pilot and other regionalization efforts, VHA will require the establishment of plans to centralized pre-registration, insurance identification and verification, and accounts receivable management activities within each VISN by the end of October 2003. Another immediate goal of the CBO 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 April 2003 in excess of 4 million claims have been generated.

VA has made front-line staff training on revenue process requirements a priority. We use the VA Employee Education Service and revenue process experts to develop education programs for core revenue business functions.

Also, as part of the immediate improvement strategy, we plan to pilot test a centralized coding pool to support two VISNs. We are also implementing point of care coding at Outpatient Clinics and developing a Charge Description Master that will eliminate the review and coding of non-billable events and increase efficiency in the coding process. To ensure accuracy and completeness of clinical information, further action is being taken to ensure that our physicians appropriately document every treatment encounter and associate requested tests and procedures with required diagnostic information. We have also mandated the use of encoder tools and claims scrubbers to enhance physician documentation and are mandating full utilization of electronic medical records effective October 1, 2003.

As part of the mid-term improvement strategies, we recognize the importance of accounts receivable payment and denial management to improve payer relationships. We are implementing a formal AR, Payment and Denial Management Program at the facility and VISN level and will require establishment of audit-appeal business processes and claims development quality controls.

Another mid-term improvement 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 the accounts receivable. Other mid-term strategies include:

- Software enhancements to ensure electronic payments from insurers -- targeted for implementation in November 2003;
- Development of encounter specific patient accounts, as well as enhancing the VistA clinical applications to collect data elements required for complete and accurate billing information;
- Development of standardized policy for pre- certification/ authorization to ensure payment of billed charges; continued stay reviews to manage "length of stay"; prospective procedural authorization and the establishment of a standardized Utilization Review process. Toward that objective, effective October 2003 pre-certification/authorization will be mandatory for all VHA facilities.
- Redesign of our Health Eligibility Center database to provide enhanced eligibility and enrollment functionality, improved data quality and data sharing capabilities. A single enrollment database will provide "register once" capability and support the delivery of consistent/reliable eligibility information across VHA.
- Enhancing and further automating the availability of compensation and award data; and
- Developing business and software solutions to automate the identification and verification of health insurance information to increase the identification of number of billable events and bring efficiencies to the process.

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. In addition, we fully anticipate increased staff efficiency through streamlined, and standardized re-engineered business processes. Also, as part of the long-term improvements in the revenue process, VHA is requiring all Veterans Integrated Service Networks (VISNs) to establish regional revenue support centers that will initially centralize pre-registration, insurance identification/verification and accounts receivable management business processes. In addition, we are planning for the activation of a National Revenue Call Center that will serve as a centralized resource for veterans' questions concerning first-party bills and assist facility and network staff to address other critical aspects of billing and collection activities. Ultimately, ongoing improvements to our VistA applications coupled with the improvement realized with PFSS and business process reengineering initiatives will contribute to further increased collections.

We are also pursuing a number of additional development efforts focused on electronic pharmacy and dental claims and Recoupment for Fee Claims Paid.

Mr. Chairman, in addition to the above actions, we are developing a demonstration project to fully outsource the revenue process functions at a single VA Medical Center to test the feasibility of this approach to enhancing revenue.

Conclusion

While improvements have been made we are not standing still. We are optimistic that with the continued implementation of the revenue action plan VA collections will reach $ 2.1 billion in FY 2004. These process improvements will include VA-wide responsibility, accountability, assignment of more stringent performance measures and incentives, structured organizational change management, and standardization and definition of performance driven expectations.

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

United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
Expected at 2 p.m.
Wednesday, May 7, 2003

VA HEALTH CARE

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

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-03-740T

May 7, 2003

GAO
Accountability · Integrity · Reliability

Highlights

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

Why GAO Did This Study

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

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

www.gao.gov/cgi-bin/getrpt?GAO-03-740T.

To view the full testimony click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

VA HEALTH CARE

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

What GAO Found

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

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

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

Mr. Chairman and Members of the Subcommittee:

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

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

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

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

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

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

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

Background

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

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

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

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

Third-Party Collections Increased

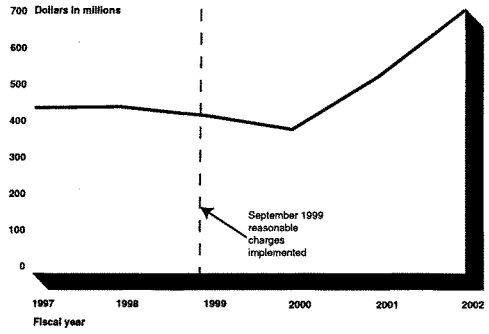
For fiscal year 2002, VA collected $687 million in insurance payments, up 32 percent compared to the $521 million collected during fiscal year 2001. Collections through the first half of fiscal year 2003 total $386 million in third-party payments. The increased collections in fiscal year 2002 reflected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

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

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

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

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



Source: VA.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concluding Observations

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

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

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

Contact and Acknowledgments

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

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

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

Source: VA.

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

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

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

Related GAO Products

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

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

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

TESTIMONY

of
Joseph Glorioso,
Director of Government Subscriber Relations
Digital Healthcare, Inc.

Before

The House Committee on Veterans Affairs
07 May 2003

Thank you, Mr. Chairman, for this opportunity to address The House Veterans Affairs Committee.

My name is Joseph Glorioso. I am the Director of Government Subscriber Relations at Digital Healthcare. Our company is the sole US licensee of various patent claims on business processes in healthcare finance, including the core issue of today's hearing - the identification of primary insurance.

VHA bills very little of its services to the private sector. The main problem VHA will have in improving billing to 30% of its care is in finding the private insurance. There are 4,000 payers and 10 Million eligibility changes per month in the US.

The audited sample reports from our National Cost Analysis that you will find in the testimony show that large private hospitals with decades of billing experience bill the wrong payer 15% of the time, and Federal health plans pay when they are not primary.

There is no doubt about the soundness of our approach. Calling 4,000 payers to check insurance would get a better result than the current method, but 4,000 phone calls would take 600 hours to complete. Our computers could search the whole market on 18,000 patients in a second. Economically, 600 hours at $15 an hour is $9,000 per admission. The online system can do the same work for a dollar.

Our whole business purpose is to use the speed of the electron to resolve this issue on every claim, faster than I can state the problem.

In the testimony you will see that the Office of Management and Budget (OMB) has testified in favor of this method in the Senate, and that the Workgroup on Electronic Data Interchange (WEDI), which included all the major payers and hospitals, said this switchboard approach was the best means to fix the problem back in 1993. You will also find in the testimony that the Senate in Oregon has a Bill declaring an emergency to use our system on its Medicaid program.

If such a process were in place for the VHA, every claim would find its way to the proper primary payer without human effort. If VHA wants that result, it will need this patented process as a component of any billing system, whether it is in-house or outsourced.

We cannot guarantee exactly how much of VHA's budget will be saved, but we can guarantee that every other source of coverage is tested before a claim is posted against the VA budget.

VHA medical center administrators whom I've met with have told me they want the automation we are offering. These experts and their peers in private hospitals have told us that our method is a quantum leap over the methods available today.

It seems to us that it is critical that the VHA notify the private provider community that this automated COB process is the "inbox" for its claims before those 58,000 trading partners expend irreplaceable Federal dollars on HIPAA systems that cannot produce this result.

We propose to tackle this problem in two phases. First, we propose to immediately commence a nine-month pilot of this system to a large sample of VHA facilities. If this pilot improves billings we propose to release the system to the remaining VHA facilities in the ensuing quarter year.

As in thousands of military development projects, it is necessary for the Congress to provide the leadership to begin this project.

In the testimony you will note the opinion of counsel that it is important for the Committee to authorize the enforcement of HIPAA as written. HIPAA gives the VHA a statutory basis to find other coverage. Lest you hear differently elsewhere, the use of this automation would save private payers a lot of money too by cutting out their manual labor on COB.

Since this is a new system for VHA, the Committee will be interested in the technical preparation Digital Healthcare has made. For this let me introduce our Chief Technology Officer, Glen Harouff.

TESTIMONY

of
Glen Harouff
Chief Technology Officer
Digital Healthcare, Inc.

Before

The House Committee on Veterans Affairs
07 May 2003

My name is Glen Harouff. Prior to taking up responsibility for the information technology at Digital Healthcare I was a senior telecom engineer with MCI.

I am here today to assure you of our ability to deliver the results of which Mr. Glorioso spoke.

Automated COB processing uses the same mechanical process as the ATM, online stock market transactions, and complex long distance telephone systems. The track record for reliability of these services is excellent.

My colleagues in Digital Healthcare's IT staff have an average of **20 years experience** in systems exactly like this one.

As you will see in our testimony package, we are fully supported by Hewlett Packard and MCI.

There is nothing untried in this plan. We are ready to deploy this for the VHA. In fact, we built a prototype of this system in 1999, and IBM-owned Sequent Computer Systems, Inc. verified that it worked.

Mr. Glorioso and I would now be happy to answer any questions you may have.

SECOND STAGE REPORT ON

THE NATIONAL COB COST ANALYSIS

Hackensack Univ. Medical Center
Patients

In March, 556 or 15.54% of your admitted population had primary coverage other than the payer billed.

In June, 570 or 15.31% of your admitted population were primary elsewhere.

In September, 582 or 15.00% of your admitted population were primary elsewhere.

At the national average (NHDS), this represents a risk of recission on $8,336,904* of your income per month.

If by also billing the primary payer your income would have increased 10%, this represents lost income of $843,068** per month.

The cost differential between HFMA's estimate and our automation of the COB issue would run $115,200*** on your number of admissions per month

The cost of full COB automation for admissions your size is $54,000 per month.

The Second Iteration contained the first 16.8 Million of an estimated 300 Million records.

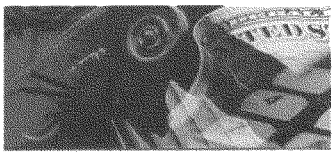
Math:

* **Average undiscovered COB events times NHDS average per day expenses, time 6 day NHDS average stay ($2,468 x 6 x newly discovered COB error rate).**

** **10% of average NHDS income, times 10% ($2,468 x 6 x .1)**

*** **HFMA estimates the cost of gathering eligibility, coverage and COB data at $50 to $100 per admission. Digital Healthcare charges $3 per patient day (here multiplied by 6) for the automation of those issues, and more.**

AUDITORS' OPINION AVAILABLE ON REQUEST



SECOND STAGE REPORT ON

THE NATIONAL COB COST ANALYSIS

Sierra Military Health Services (USDoD Tricare)

13,646 (1.82%) of your insured population were primary elsewhere in March,

13,498, (1.79%) of your insured population were primary elsewhere in June, and

13,525, (1.80%) of your insured population were primary elsewhere in September,

Three-Identifier Match

•

Sierra has measured actual claims paid on these undiscovered COB events at
$2,720,000 in March,
$2,834,000 in June, and
$2,356,803 in September

The cost of full COB automation for a group your size is $750,000 per month.

The average result of all participants in this Second Iteration of the National Demonstration was a loss of 9.69%. The Second Iteration contained the first 16.8 Million of an estimated 300 Million records nationwide.

AUDITORS' OPINION AVAILABLE ON REQUEST

SECOND STAGE REPORT ON

THE NATIONAL COB COST ANALYSIS

Government Employees Hospital Assn

In March, 73,341 or 16.7% of your insured population were primary elsewhere.

In June, 72,914 or 16.6% of your insured population were primary elsewhere.

In September, 73,067 or 16.6% of your insured population were primary elsewhere.

At the national average, this represents an unnecessary loss of $15,206,000 per month.

The cost of full COB automation for a group your size is $440,272 per month.

The average result of all participants in this Second Iteration of the National Demonstration was a loss of 22.13%. The Second Iteration contained the first 16.8 Million of an estimated 300 Million records nationwide.

AUDITORS' OPINION AVAILABLE ON REQUEST

SUPPORT OF THE DIGITAL HEALTHCARE THESIS FROM GOVERNMENT AND INDUSTRY GROUPS

"We envision an on-line, up front query system in which the primary and secondary payers will be determined at or before the time that care is provided, thus eliminating the need for after-the-fact attempts to match data across various data bases, or the continuation of the Medicare Data Bank."

Deputy Director, USOMB
To the Senate Finance Committee
1995

"To achieve the ultimate goal, a central directory of enrollment information must be maintained to determine primacy....The directory would receive enrollment information from insurers, apply the standard rules of primacy of coverage and payment responsibility, and code and array the policies for each insured individual accordingly."

Workgroup on Electronic Data Interchange
1993

PROPOSED AMENDED SENATE BILL 865
SENATE OF THE STATE OF OREGON

Delete lines 4 through 15 and insert:

SECTION 1. (1) The Department of Human Services shall establish an automated, online provider payment submission system for the medical assistance program. When a provider submits a claim for payment, the payment submission system shall identify and bill any primary or secondary payer before billing the medical assistance program.

(2) To operate the system, the department shall contract with an organization with expertise in automated, on-line provider payment submission systems having the capacity to automate the coordination of benefits.

SECTION 2: (1) The Department of Human Services shall establish a committee to assist and advise the department in obtaining a contract for the automation of coordination of benefits for the medical assistance program as described in section 1 of this 2003 Act....

SECTION 3: This 2003 Act being necessary for the immediate preservation of the public peace, health, and safety, an emergency is declared to exist and this 2003 Act takes effect July 1, 2003.

Senator Bill Fisher

Mitchell Roberts
Hewlett-Packard Company
3817 Autumn Glen Drive
West Chester, OH 45069
PH: (513) 543-9083
FX: (513) 759-0648

" I couldn't even begin to tell you what the cost of downtime would be. Our execution systems must be available at all times the market is up. We kind of take it for granted that the HP NonStop won't go down."
John Hickey, Chief Technology Officer, NASDAQ

"The <Non-Stop> system has always been available whenever we have required it. We've never had any significant downtime across our applications in 18 years."
Hugh Tompson, Director of Information Systems Northumbria Police Force

"We are very pleased with what he calls the "truly continuous" availability of the *NonStop Himalaya* platform."
Mark Badgely, VP Bank One Services

April 21, 2002

Glen Harouff
Chief Technology Officer
Digital Healthcare, Inc.
PO Box 970732
Cleveland, OH 44147

Dear Mr. Harouff:

Hewlett Packard Corporation is the largest provider of data center hardware and systems consulting in the world.

Our computers and professionals handle an average of 3 Billion messages per day on NASDAQ, and the main transaction volume of 106 out of 120 stock markets around the world. Our computers handle the vast majority of the world's Credit Card, ATM, Securities and EFT traffic, and various other mission critical applications for public safety and e-commerce.

The fact that our data centers at the New York Stock Exchange and the Chicago Board of Trade have never been down in two decades of service has persuaded Digital Healthcare of our ability to support your important mission in protecting the fiscal integrity of Federal, state, and commercial health plans by automating COB, while also delivering fail-safe service to the medical community.

We have been involved in the deployment of automated COB processes as a principal vendor to Digital Healthcare for a number of years. Consequently, we have a detailed familiarity with the scope and the importance of Digital Healthcare's mission.

Hewlett Packard is fully supportive of this improvement in the healthcare finance system, and in our opinion, the automation of COB and its related processes can readily be delivered.

Yours,

Mitchell Roberts
Hewlett-Packard Company
(513) 543-9083

mitch.Roberts@HP.com

DIGITAL HEALTHCARE, Inc.
Enhanced Electronic Commerce

01 May 2003

Hon. Steven Buyer
Chairman,
House Committee on Veterans Affairs
Capitol Hill
Washington, DC

Dear Representative Buyer:

Please accept this letter as a brief legal opinion in support of the Committee's request for testimony on the automated identification of health coverage for veterans presenting themselves for care at VA medical facilities.

42 USC 1320(d) (also known as the Health Information Portability and Accountability Act of 1996 or HIPAA) provides that health plans will reply to any eligibility inquiry or claims in an even-handed and standard electronic message when the Act takes effect on 16 October of this year.

We have corroborated a formal statement of Congressional intent that was made a part of the public record by the author of the Bill, Representative Hobson, in 1997 and have spoken with the Congressman to corroborate the legislative intent again this year.

Taken together with our organization's intellectual property and ten years of systems development, a delegation of agency by the Congress or the Veterans Administration to Digital Healthcare can result in the identification of 100% of the private sector coverage of our veterans, without undue paperwork by the veterans or the VA staff, in real time, and the electronic delivery of the bills developed at VA institutions to the proper primary payer.

It seems probable that this would result in the improvement to outside billing that the Committee, the GAO, the OMB, and the VA have targeted.

Yours,

Steven M. Ott
Secretary and General Counsel

PO Box 470732
Cleveland, OH 44147
Ph.: 216-861-2300
steven.ott@dhinc.biz

VETERANS AFFAIRS PILOT PROGRAM
ONLINE COB SYSTEMS

Objective

The objective of the VA Pilot on Online COB Systems is to engage in a live test of an automated, pre-emptive search coverage existing in the private sector for veterans presenting at VA medical facilities to determine:

a) whether an online, comprehensive search with the standard rules of COB applied finds other coverage more efficiently than the status quo ante or other methods can do,

b) whether the integration of digital fingerprint system similar to that in use by TriCare enhances patient safety,

c) whether design enhancements are in order in the opinion of the Chief Business Office and line staff at the participating VA facilities, and

d) whether VA line staff at Admitting and Billing prefer the online COB system to other means of gathering the same data.

Steps

In order to gather a variety of experience, and to maximize the benefit to be gained by the VA from an investment in establishing data links with private payers, the pilot should include all the VA facilities in VISNs 3,4,8,17,21 and 22 and should include an Online testing period of not less than four months. The steps of the nine-month pilot include:

1) Execution of a pilot Agreement, delegating agency to act for the VA facilities and to enforce HIPAA provisions on e-commerce,

2) Initial notice and the scheduling of training for VA admitting and billing personnel at the 200+ facilities in the pilot design,

3) A period of notice to the private sector payers and to private medical facilities in that may wish to bill the VISNs,

4) Uploading of basic eligibility information to the Digital Healthcare data structure and determination of regular upgrades by the VA,

5) Reminder training for VA personnel near the start date of the interfaces,

6) A four month period of systematic utilization by VA admitting and billing personnel,

7) A ten day debriefing and performance questionnaire process to determine the efficiency, deficiencies, and preferability of the online COB system.

8) Delivery of a Report to the Chief Business Office and the Congress.

Timeline

Step	June '03	July	Aug	Sept	Oct	Nov	Dec	Jan '04	Feb
1									
2									
3									
4									
5									
6									
7									
8									

Anticipated Results

Currently, the VHA reports billing 3% of the services rendered by VA facilities to the private sector. The pilot should demonstrate a significant increase in identified private coverage for those billing events as a percentage of overall care.

The pilot should show that admitting and billing personnel favor the Online COB system over their available alternatives as a means of accomplishing zero defects in private sector billings.

The pilot should arrive at a cost-benefit conclusion with respect to deploying the Online COB system throughout the VA medical facilities.

Reporting

For each participating VA facility and in the aggregate, the Pilot will report:

	Item	Metric
1	Number of Outpatient Visits	#
2	Number of Inpatient Days	#
3	Number of Correct 'Other Coverage' Records	#
4	Number of Corrected 'Other Coverage' Records	#
5	Number of New "Other Coverage' Records	#
6	Number of Payer Dbases Interrogated	#
7	Number of HIPAA Enforcement Actions Commenced	#
8	Number of Billable Dollars Found	#
9	Number of Failed Inquiries	#
10	Number of Failed Interface Devices	#
11	User General Satisfaction	1-10
12	Comment Sheets	Text

Before the House Subcommittee
On Oversight and Investigations
Of the House Veterans' Affairs Committee

Testimony of Donald N. Blanding
Healthcare Information Technology Consultant
Novus LLC
Fargo, ND

Executive Director Information Technology (Ret)
Fairview Health Services
Minneapolis, MN

Wednesday, May 7, 2003

Thank you Mr. Chairman and distinguished members of the Subcommittee for providing me with the opportunity to appear before you today. My name is Don Blanding, and I've spent the last 18 years of my career in healthcare information technology, nearly all of it as Executive Director for Information Services at Fairview in Minneapolis, Minnesota. The Minneapolis / St. Paul Metropolitan area has been a highly competitive environment for healthcare dating back to the 1980's. HMO's have been big players for some time. Likewise, employer coalitions have been used to leverage bargaining power and reduce healthcare costs. As a healthcare provider, this translates into increased competition and reduced margins.

Fairview Health Services is a $1.5 billion dollar not for profit healthcare company consisting of seven "care systems". Each care system includes a hospital, clinics, a skilled nursing facility and home care. The largest care system includes Fairview University Medical Center, the teaching hospital of the University of Minnesota, and surrounding facilities. There are two other large metro care systems and four smaller care systems located in
Rural Minnesota.

Much of my time at Fairview focused on revenue cycle management. For our purposes today, I'll define revenue cycle management as all of those processes required to insure the successful and timely capture of revenues due the institution for patient care provided. Care may be provided in many settings, including clinics, hospitals, ambulatory care centers, skilled nursing facilities, and in the patient's home. Revenues come from Medicare, Medicaid, private insurers, HMOs, and the patient. In the next few minutes I'd like to highlight just a few of the more critical steps in the revenue management cycle and, in some cases, how they might be addressed. My focus will be typical hospital visits. Please note that nearly all of this effort takes place long before the patient bill or insurance claim is ever produced.

For example, pre admission and pre certification take place before the patient presents at the facility. Accurate patient demographics and "certifying" that the patient is indeed insured for the upcoming procedure needs to be done very early in the process. Large institutions have a computerized list (referred to as the master patient index or MPI) of names of former patients and guarantors. Fairview's MPI consists of 3.3 million names. When a patient presents, it's understandably important that, before adding a new entry to the MPI, that we are not creating a duplicate entry. Creating multiple MPI entries for the same person has obvious clinical and financial ramifications. Likewise, assigning the presenting patient with the wrong MPI number is equally problematic.

At Fairview, computer logic assists the admitting clerk in finding the right match. Phonetic searches help locate similar names and addresses. If the computer "thinks" that a wrong choice has been made, the admitting clerk and their supervisor receive an automatically generated email. Once it's been determined that an error has occurred, the computer includes logic, for example, to combine clinical and financial history of two MPI entries for the same person, likewise, logic exists to separate information belonging to two people but collected under one MPI entry. Reports are also generated that are designed to track occurrences of these problems. These reports are used to help isolate trouble spots and take appropriate action. Actions may include staff training, improving procedures and processes, and working with unique payer requirements.

Once admitted to the facility, it may be determined that additional procedures are medically necessary. Another certification process is now done for the same reason as prior to admitting: To verify insurance coverage.

During the hospital stay the process of charge capture becomes important. Simply stated, this amounts to making sure that the right supplies, pharmaceuticals, lab

tests, x-rays, etc., are charged to the right patient account. In some hospitals, a dispensing machine not unlike a candy vending machine is used for supplies and some pharmaceuticals. The caregiver must key in their identification and the patient's account number before the item is dispensed. This somewhat expensive approach effectively forces the caregiver to document how the dispensed items are used. The charge master is a computer file that contains an entry for every conceivable item, service, room utilization, etc., that might be charged to the patient. At Fairview University Medical Center, the charge master contains 300,000 entries. These entries are maintained in over 15 departments. Keeping the charge master populated with timely, accurate data is a challenge in itself.

In a capitated or prospective payment environment, providers are paid based upon previously arranged contracts that itemize fixed payments for specific procedures, regardless of the costs incurred by the provider. In these cases, charge capture has no impact on the amount the provider can expect to be paid. Payment is independent of the cost (charges) incurred by the provider. However this cost information is every bit as much important in tracking the expenses incurred in treating a given episode. Only then do we know the margin between the cost of providing the service and the payment received.

The January, 2003 GAO report makes reference to a 1999 VA initiative to establish "reasonable charges" for a particular service. As I understand it, this initiative positioned the VA to more accurately charge payers for services provided. In my experience this is only the beginning in a negotiation process to determine what the payer is willing to pay for that service. I'm unsure as to how this works with the VA and their payers.

Once the patient leaves the hospital, several steps are required prior to preparing the patient bill. First the medical record (the "chart") must be completed at the nursing station. Then the physician dictates the discharge summary and signs the resulting transcribed report. Historically, the process often stopped here because physicians failed to sign these reports (attestation) in a timely manner. In an effort to improve cash flow, we wait for physician signatures in only the most complicated cases (such as solid organ transplant).

Coding then takes place in the medical records department. Medical records coders review the chart and, with computer assisted logic, assign ICD9 codes to the procedures described by caregivers. Computers further analyze this and assign a diagnostic related group (DRG) for the episode of care. Remember that the DRG is the code that provides the payment from Medicare. There are several computer software packages available to assist in the coding process. Only now can the

patient bill and insurance claim be produced. The Fairview benchmark here is six to ten days post discharge, depending upon the institution and the complexity of the case.

Once the bill and claim are produced, the cycle continues by tracking by payer, the number of elapsed days prior to payment, referred to as days in receivable. This varies considerably by payer, as most are in no hurry to pay their bills. (Interestingly enough, Medicare is often one of the more timely payers.) Days in receivable by payer reports direct management to the areas that need the most attention.

Bad debt is also monitored and is probably the most watched over statistic. Bad debt may be defined here as amounts determined to be uncollectable due to a problem in any of the processes in the revenue management cycle. Bad debt is tracked by payer, by institution, by procedure, and any other way that helps to isolate problems. A bad debt rate of 1.75% (of total revenues) is an achievable goal. Considering that many of our country's not for profit hospitals struggle to reach a positive bottom line and revenues may exceed expenses by 1 to 2%, the bad debt ratio is an important management tool.

SUMMARY:

Many hospital employees and staff have an impact on the revenue management cycle. To improve collections, each process needs to be carefully analyzed and documented. To the extent possible, the focus should first be on the process, not the people.

All of these processes are measurable. Measurements provide goals and objectives for employees and staff. Policies and procedures can be put in place to meet the objectives. Managers and staff need to be held accountable for meeting the objectives.

Many reasons may be offered as to why the revenue cycle is problematic or where objectives can not be met:

* Our patients are older
* Our patients are sicker when the first present
* Our payer mix is skewed to difficult, low paying insurers
* Our staffing levels are too low.

My response to these arguments is to first establish goals and objectives which include staffing levels and then look for "20% -80% situations, where 80% of the problem is in 20% of the occurrences. Further, industry benchmarks are available, and need to be applied.

Having had the opportunity to review prior studies done at Veterans' Administration hospitals, including the recent work by the GAO, I would further share the following observations.

First, there seems to be an emphasis on collections after the patient bill or insurance claim is produced. This is too late. The focus needs to be on the processes discussed, starting before the patient is admitted. Insurance companies deny payment primarily because of problems that occur in these processes.

Secondly, the GAO report makes reference to "missed billing opportunities". Reference is made to one study where 5.5% of the patient episodes that could have been billed were not billed. This simply would not be an issue in the private sector. If a patient is seen, a bill is produced.

Thirdly, the GAO report is silent on the subject of co pays. A co pay is the amount the insurance company expects the patient to pay before any care is provided. In my experience, these collections are closely monitored against established metrics. If it's not happening now, the VA should be doing the same.

Fourthly, the GAO report includes text on the use of professional fees ("pro fees") and facility fees. Pro fees are the provider's charges and facility fees are the charges for the use of the "facility", in this case the VA. In my experience, payers have very little interest in this distinction. Claims for facility fees are often simply ignored. The VA should monitor their success in this arena.

We're all familiar with the significant changes in health care economics over the past 20 years. Prospective payment, shorter hospital stays, significantly more expensive procedures, lower staffing levels, reduced physician compensation, and many other factors add to the stress and frustrations for those of us in the industry. It would appear that the VA needs to step up to the plate, address these issues in terms of benchmarks already available, knowing that VA employee job descriptions and accountabilities may change, and along with it some temporary increases in stress levels during the process.

Finally, this should NOT be looked on as an initiative to reduce the quality of health care available to veterans. Rather, it is a series of process improvements to collect revenue for care provided in a manner consistent with the patient care and financial management found in nearly all of the leading healthcare organizations in the country. An improved revenue cycle allows opportunities for improved patient care without further burden to the taxpayer.

Thank you for allowing me to testify.

STATEMENT OF
CATHLEEN WIBLEMO, DEPUTY DIRECTOR FOR HEALTH CARE
NATIONAL VETERANS AFFAIRS AND REBILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
THE MEDICAL CARE COLLECTION FUND (MCCF)

MAY 7, 2003

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the Medical Care Collection Fund (MCCF). We commend the Subcommittee for holding a hearing on this important program.

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veterans Affairs' (VA) MCCF and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. MCCF is a depository for funds collected from third-party reimbursements from private insurance plans, outpatient prescription copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal government.

Funds collected through MCCF are used as an offset rather than a supplement to annual discretionary appropriations for VA's medical care budget. The efficient and timely collection of these reimbursable costs greatly benefit the VHA in meeting the demands of an increasingly overburdened system. By off-setting these funds VA loses valuable funding that is not an accurate representation of the veterans' population in Veterans Equitable Resource Allocation (VERA) formula nor does it allow for the full utility of collecting from the nation's largest health insurance provider - Medicare.

Currently, VA distributes discretionary funds to its 21 Veterans Integrated Service Networks (VISNs) using the detailed VERA formula. Although VERA contains numerous allocation components, neither the number of enrolled Priority Group 7 and 8 veterans nor the number of enrolled Medicare-eligible Priority Group 7 or 8 veterans are allocation factors. Yet VA treats these veterans for nonservice-connected medical conditions with the expectation of collecting both co-payments and third-party reimbursements. When these Priority 7 or 8 veterans have no private insurance or list Medicare as their third-party insurer, VA cannot recoup the reasonable cost of care for the treatment of nonservice-connected medical conditions. Since over half of the current enrolled population consists of Priority Group 7 and 8 veterans, this is an extremely critical funding flaw.

These fundamental elements are crucial to improving MCCF's ability to improve the level of funding for VA health care. VA must have the ability to bill, collect and administrate more effectively a system established to help recover third-party reimbursements for the treatment of nonservice-connected medical conditions. MCCF needs to utilize a viable means to help VA effectively recover third-party reimbursements owed to VA. The use of model agencies' successful collection system, such as the Indian Health Services (IHS), can increase the efficiency of MCCF activities.

OFFSET OF MCCF TO DISCRETIONARY APPROPRIATIONS

Offsetting collections are monies that are deducted from outlays rather that counted on the receipt side of the budget. Outlays are the amount of money the Federal government actually spends in a given year. Offsets are often payments received for goods or services provided by the Federal government, such as medical care given to veterans by VA who are already covered under another health plan (public or private). The Debt Collection Improvement Act of 1996 (DCIA), Pub. L. 104-134, 110 Stat. 1321, (Apr. 26, 1996), as codified in 31 U.S.C. 3716(c), requires the Department of the Treasury (Treasury) and other disbursing officials to offset Federal payments to collect debts owed to the United States. This also applies to debts "owed" to the Treasury by Federal agencies that calculate offsets into discretionary budgets.

Technically, MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF Treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, it appears that the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. The American Legion fails to understand the difference in the net effect to the VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

IMPROVING MCCF COLLECTIONS via INDIAN HEALTH SERVICES MODEL

Recent changes by the Veterans Health Administration (VHA) in the way medical care costs are recovered has had a dramatically positive effect on the amount of revenue collected. The implementation of the VHA Revenue Cycle Enhancement Plan in early FY 2002 resulted in significantly higher receipts than projected; so much so that VHA recently doubled the amount VA expects to receive in FY 2004 from $1.03 billion to $2.1 billion. However, MCCF system can benefit from agency models that clearly exemplify the efficiencies gained through practical application.

Five members of The American Legion's National staff visited IHS Headquarters in Rockville, MD to review and discuss the IHS experience with Medicare billing and collection. This was followed by a site visit by four National staff members to the Albuquerque Area Office of IHS for a detailed overview of the "Third Party Revenue Cycle." This was an extensive briefing on

the individuals, interactions and functions necessary to generate revenue collection, with a particular emphasis on the Medicare component. Afterward, three National staff traveled to the Acoma-Canoncita-Laguna (ACL) Hospital in San Fidel, NM for a demonstration of the billing and collection process.

BACKGROUND

IHS was established to meet the government's responsibility to provide health care to Native Americans. Like VA health care, it is not an "entitlement" program. Primary care is their basic mission, but they also deal with Public Health issues, such as sanitation. IHS treats about 1.5 million patients a year (based on use within the past three years) of a population census of 2.2 million. There are about 50 facilities, many of them small rural clinics.

In 1976, Congress enacted title IV of the Indian Health Care Improvement Act (IHCIA) which amended titles XIII (Medicare) and titles XIX (Medicaid) of the Social Security Act (SSA). This allowed IHS to bill for medical services provided by IHS facilities to Native Americans eligible for Medicare (Part A) or Medicaid. Billing for Medicare Part B was authorized in 2002.

Initially, there was cultural and bureaucratic resistance to the billing and collection of Medicare and Medicaid. In 1990, IHS collected only about $200,000. After absorbing significant cost increases that were never funded in FY 1992-1996, an emphasis was placed on collections for sheer survival. IHS now collects about $500 million a year. Of this, about $100 million is from Medicare billing. The bulk of collections come from Medicaid, which is consistent with the circumstances of the Native American population where, historically, there are lower incomes and shorter life spans.

FINDINGS

Medicare billing and collection has been successfully implemented within IHS. The benefits of successful implementation:

- ✓ Improved quality of care
- ✓ Accurate and complete medical documentation
- ✓ Enhanced provider profiling capabilities
- ✓ Reduced malpractice and tort action liability
- ✓ Improved Risk Management for physicians and hospitals
- ✓ Facilitated Quality Assurance
- ✓ Compliance with rules and regulations
- ✓ Third-party resource maximization

KEY ELEMENTS

In contrast to Department of Defense (DOD) Medicare Subvention Pilot Demonstration, IHS has no level of effort associated with its Medicare collection program. IHS collaborates with the Services Center for Medicare and Medicaid, (CMS) through an advisory group that deals with policy decisions. There must be "buy-in" from the top with leadership focused on and closely monitoring the process. There was an initial investment in training people, and there was a

learning curve in the business process, where there is a deliberate billing process that requires attention to detail. A major lesson learned was too much emphasis on the billing process rather than the collection of accounts receivable. Although billing is important, accounts receivable activities ultimately determine a successful collection rate.

Everyone in the process must understand their role. The training of coders is extremely important, and the coders should be certified. Pay grade of certified coders should be more comparable to the private sector for successful recruitment and retention purposes. IHS and DOD use electronic medical records that have the capability to generate billing information. It was suggested that software solutions are now available that make it feasible for VA to succeed in the business practice.

CONCLUSION

The Indian Health Service's experience with Medicare collections demonstrates that a Federal agency can successfully manage Medicare billing and collection. It further creates a blue print that is applicable to similar action by VA, when reimbursement is authorized. IHS has had a targeted goal for the use of its Medicare and Medicaid collections since inception: to improve the quality of care, in particular, as indicated by accreditation, such as, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO scores for the 2001 Corporate Survey of the six facilities within the Albuquerque IHS Area ranged from 92 to 97. All were above the national average score of 88. This would seem to indicate that success in the revenue collection program has correlated with success in meeting the accreditation goal.

IHS has a 10-year exemption (through 2004) from reporting to CMS the actual cost of care. IHS personnel have develop a process for capturing such data actually based on VA's data collection model.

The American Legion is pleased with the progress in collections that VHA has made to date. If VA is to provide timely access to quality care for veterans, MCCF must become a substantial portion of VHA's operating revenue. The American Legion supports the President's FY 2004 budget request's legislative initiative requiring Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) to consider VHA a network provider or preferred provider, respectively. This legislation would prevent HMOs and PPOs from using the lack of a participating network or preferred provider agreement as a reason for non-payment to VA for services provided for other than urgent conditions.

If VA can become a network provider or preferred provider for HMOs or PPOs, The American Legion wonders why VA can't become a designated Medicare provider, as well.

The American Legion also supports another legislative initiative in the President's FY 2004 budget request to require enrolled veterans to identify all of the public and private health insurance coverage to help facilitate VA's billing and collection activities.

MEDICARE REIMBURSEMENT TO MCCF

Medicare is a Federal health insurance program. Nearly every person is mandated, by law, to make monthly contributions to Medicare throughout his or her working career. Employees must pay 1.45 percent of taxable wages. The employer must match that amount, yet unlike Social Security, there is no cap. Therefore, the majority of beneficiaries make significant monetary contributions to Medicare before ever becoming eligible for coverage. The more money made by an individual, the higher the combined payment to Medicare. Medicare is a pyramid-based funding scheme – spreading out the risk among its ***potential*** beneficiaries and those who are actually receiving coverage. Medicare is considered an entitlement; therefore, it receives annual Federal mandatory appropriations.

Generally, any person is eligible for Medicare if:

- that person or their spouse worked for at least 10 years in a Medicare-covered employment,
- that person is 65 years of age or older, and
- that person is a citizen or permanent resident of the United States.

Others may qualify for coverage if:

- they are under age 65 with severe disabilities, or
- are diagnosed with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two basic components:

- Part A (Hospital Insurance) – basic coverage provided for allowable health care services.
- Part B (Medical Insurance) – additional coverage available on a premium basis for additional health care services.
- Supplemental Coverage – available through private insurance providers on a premium basis for charges not covered by Part A and Part B coverage.

Medicare offers certain choices to include:

- The original Medicare program, or
- Medicare+Choice including Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans.

VHA is the largest Federal integrated health care delivery system. Eligibility for enrollment in VHA is based on honorable military service and limited by existing appropriations. Currently, there are 24 million veterans. Nearly 7 million are currently enrolled in VHA, but thousands of additional veterans are waiting to enroll. Currently, access to care is determined on a priority basis. Priority Group 1 has the highest priority to care, while Priority Group 8 has the lowest priority to enroll for care. Each Priority Group is clearly defined in Title 38, United States Code (USC).

Although access to VHA is an earned benefit, it is not considered an "entitlement"; therefore, funding is dependent upon annual discretionary appropriations rather than mandatory appropriations. Title 38, USC, identifies which veterans shall receive care at no personal cost. VHA is authorized to bill, collect, and retain all co-payments and third-party reimbursements.

The Medicare Trust Fund is funded to make reimbursements for quality health care delivered to beneficiaries by qualified Medicare providers. VHA, like IHS, provides quality health care to a unique patient population by using a combination of funding sources: discretionary appropriations and third-party reimbursements.

Mr. Chairman, in passing the Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. 104-262, Congress required VA to furnish hospital care and medical services to, among others, any veteran with a compensable service-connected disability or who is unable to defray the expenses of necessary medical care and services. It further authorized the VA, with respect to veterans not otherwise eligible for such care and services, to furnish needed hospital, medical, and nursing home care.

The overwhelming response from the veterans' population was largely unanticipated and badly under funded, leading to the recent suspension of Priority Group 8 veterans enrollment. The American Legion believes the VHA is on the right track to developing the fiscal means to comply with the Congress' intent to provide health care to all this nation's veterans. Allowing access to all available Federal and non-Federal funding sources and to achieve the efficiencies described above can only accelerate VA's compliance with that mandate.

Finally, The American Legion is deeply concerned about veterans with no private health insurance. The American Legion strongly recommends Congress consider authorizing VA to offer health benefit packages on a premium basis much like DoD's TRICARE program. When DoD was faced with meeting timely access standards for military retirees and dependents, it created TRICARE which offers premium-based health benefit packages based on the individual health care needs of its beneficiaries. The American Legion believes a similar benefit should be made available for Priority Group 7 and 8 veterans, especially those currently prohibited from enrolling. The funds collected through premium-based health care plans would provide a much needed additional revenue stream for an already over burdened system.

Thank you for this opportunity to present The American Legion views on this important topic. That concludes my testimony.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Steve Buyer, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
May 7, 2003

Hearing on VA's Progress on Third Party Collections

Question 1: In Karen Sagar's (the MCCF Director at the Martinsburg WV VAMC) testimony before the Subcommittee on September 21, 2001, she stated that her section, the Business Programs and Operations Service, had 8 FTEE in the Coding/Billing Unit. Does the Chief Business Office include the cost of coders' salaries and training in its "cost to collect?" If not, why not?

Response: Consistent with health care industry standards, the "cost to collect" metric, which is calculated by dividing operational costs by total collections, does not include salaries of medical records coding staff.

Question 2: In VA's testimony, the figure $2.1 billion is used for the amount VA expects to collect in FY 2004. Is this based upon the current copayment rate?

Response: No. The figure of $2.1 billion includes all the recommended policy changes as presented in the President's FY 2004 Budget Submission.

Question 3: According to the GAO, VA has completed 10 of the 24 detailed recommendations in its Revenue Cycle Improvement Plan of 2001. When will the VA complete the remaining 14 recommendations? Are they being incorporated into a new plan?

Response: VA is continuing to pursue the objectives of the 2001 Revenue Improvement Plan. Of the original 24 Action Items, 14 are fully completed; one was deemed cost ineffective and cancelled; and nine are on target for completion.

With the establishment of the VHA CBO, an expanded revenue action plan has been formulated that combines the 2001 Revenue Improvement Plan with a series of industry proven tactical and strategic objectives, including establishment of industry based performance and operational metrics, development of technology enhancements and integration of industry proven business approaches including the establishment of consolidated patient account centers. Attachment A provides further information on the 2001 Revenue Improvement Plan and the expanded revenue action plan.

4. When VA fails, upon an initial attempt, to collect an adequate payment from insurance companies what additional follow-up steps does it take? In general, how successful are follow-up attempts?

Response: To collect from an insurance carrier, facilities have a number of tools that they employ for follow-up including: letters, telephone calls and use of contract staff both on and off site. Additionally, accounts receivable staff work closely with utilization review staff on writing appeals based on medical denials. Success in follow-up attempts is judged by the VHA's performance metric for percentage of accounts receivable days over 90 days delinquent. VA tracks these performance metrics on a facility level and they are posted to the Chief Business Office website and presented to the VA's Business Oversight Board chaired by the Secretary. For the third quarter of FY2003, VA's overall percentage of accounts receivable greater than 90 days was 41.8%, which is well ahead of the targeted goal of 55% at the end of this time period.

Question 5: In testimony it states that VA has implemented electronic claims generation. Where is this being done? What benefits have been derived from this? How much has this reduced the processing time?

Response: The transition to total electronic claims generation is underway at all VA facilities. The percentage of electronic bills is increasing as additional insurers are being brought on board electronically, notably certain Blue Cross Blue Shield plans. Furthermore, at present, most health plans do not accept electronic secondary claims. When HIPAA electronic transactions standards go into effect on October 16, 2003, we expect a greatly expanded number of health plans to accept secondary claims electronically. Data from one of VHA's first sites to install electronic billing do provide preliminary evidence of the benefits of electronic billing. Time from the issuing of bills to receipt of payment has moved from an estimated average, before electronic billing, of 30-45 days to a current estimated average of 7-14 days. At this site, biller productivity has risen 42% since electronic billing software came into use.

Question 6: How did VA determine that 20-25% of enrolled veterans have additional health insurance?

Response: The estimated percentage is based on a 2002 VHA Survey of Veteran Enrollees. According to the survey, 78% of veterans enrolled in the VA health care system have some type of public or private health care coverage, including 56% who have some type of Medicare coverage (not billable by VA) and 12% who are in HMO plans, many of which limit or exclude out-of-network payments. Additionally, data indicate that 13% of the enrolled veterans have billable insurance through Fee for Service Plans and 28% percent through Medigap plans.

Question 7: What is VA's level of confidence in the accuracy of the numbers on which it bases its cost to collect?

Response: As discussed in the response to Question 1, the current cost to collect data is generally reliable but not without vulnerability because of operational costing variability and Medicare adjustment factors.

Question 8: In its April 2003 CAP review of the VA Roseburg Health Care System in Oregon, the Inspector General's Office identified 10,393 insurance accounts receivable with a total value of $1.9 million. Of these, 8,679 insurance accounts were older than 90 days with a value of $1.3 million. The IG, in consultation with MCCF supervisor, estimated that if the MCCF staff more aggressively pursued these claims they could increase the amount collected by 5%, or $65,000. Does the Chief Business Office agree with these numbers? Why weren't claims contracted out, per Dr. Roswell's directive from last year?

Response: The Chief Business Office has contacted the medical center and spoken with the Supervisor referenced in the CAP report for Roseburg. To this individual, the figure of 5% referenced represented an overall perspective on how much an aggressive AR program could bring annually in terms of additional revenue. Relative to the specific claims over 90 days ($1.3 million) referenced in the CAP report, we believe based on a facility's typical distribution and collections for non-medigap and medigap receivables, the collection potential to be $520,000 for this set of receivables, or 40% of the $1.3 million. This assessment is based on national trends and standards.

In the directive from Dr. Roswell, facilities were given the option of not contracting out if they were able to provide demonstrated evidence of a better in-house program. At the time of the memo from Dr. Roswell in May of 2002, Roseburg provided evidence to that effect to the Network. However, subsequent staffing shortages caused a backlog. The CAP report indicates that the staffing plan presented by the facility was acceptable and the issue considered resolved.

9. Why doesn't VA separate Medigap collections from other insurance collections? If they were separated, would that give both VA and Congress a truer picture of the Chief Business Office's successes and efficiencies?

Response: Existing VA data systems do not currently accommodate a stratification of third party receivables that enable separation of Medigap and non-Medigap bills. However, effective November 2003, with the implementation of the Medicare Remittance Advice capability, VA will be able to do so.

Question 10: How can VA assure Congress that it will finally reach an agreement with CMS on the Medicare Remittance Advice issue this November?

Response: VHA is working closely with CMS and Trailblazer Health Enterprises, a CMS-contracted Medicare Fiscal Intermediary and Carrier, to have an electronic MRA process in place in November 2003. We are now in the process of conducting user acceptance testing, which is a final step in the development process. As a result, we do not anticipate any delays in completing this project in November.

Question 11: How can the discrepancy between the collections staff salary numbers provided by the Chief Business Office and the Office of Policy and Planning be described?

Response: The Chief Business Office (CBO) and the Office of Policy and Planning (OPP) use the same data source to gather information on both the number and salaries of collection staff. However, discrepancies can occur if each office submits responses reflecting numbers of positions and salaries at differing points in time. To illustrate, on February 10, 2003, the Office of Policy and Planning reported that as of March 31, 2002, the MCCF total positions were 2,295 with salaries including full-time and part-time at $79,788,986. As of March 31, 2003, MCCF total positions were 2,826 with salaries, including full-time and part-time at $101,259,819. Thus, between March 31, 2002, and March 31, 2003, there was an increase of 531 total positions.

To avoid reporting discrepancies in the future, both the CBO and OPP will work more closely together to ensure that the information provided is clearly defined.

Question 12: What steps is the VA taking to ensure full utilization of electronic medical records by October 1, 2003?

Response: The utilization of the electronic record is being monitored through an existing monitor of clinician order entry, and beginning in FY 2004 an additional monitor of electronic notes per each encounter will be added. The performance monitor on order entry by clinicians has shown a steady increase in compliance with an overall rate of 91%. A new monitor on progress notes associated with a clinic visit will be released in the fall of 2003.

Question 13: Will the VA be HIPAA compliant by November 2003? How long will HIPAA implementation take?

Response: VHA is already complying with the Privacy Rule of HIPAA and expects to be compliant with the Electronic Transactions and Code Sets Rule by the October 2003 deadline. VHA will continue to assess and modify its business functions as needed to accommodate the requirements of the Security Rule by the April 2005 deadline.

Question 14: Please rank order facilities from most efficient to least efficient in collections. Please also provide this list in net collections?

Response: VA establishes collection goals for each facility and uses them to measure the facilities' level of effectiveness. We have included the ranking of each VHA facility by their percentage collection to goal, using both Medicare adjusted and unadjusted figures. We monitor them using targets and a color-coding scale as described in our answer to question 17. (See Attachment B.)

Question 15: What type of action is being taken to ensure that all health care providers accurately document every treatment encounter and associated tests and procedures with required diagnostic information?

Response: The Clinical Indicator Project, Iteration #1, will be released to the field in November 2003. This project will require the clinician to associate a diagnosis for each ancillary service, medication, or prosthetic item ordered. Electronic encounter forms are being used to assist with correct coding of diagnoses and procedures, and available local and national documentation templates prompt clinicians for needed documentation.

Question 16: When is the VA planning for the activation of a National Revenue Call Center?

Response: The VA Health Revenue Center (HRC) in Topeka, KS, anticipates implementing a Revenue First Party Call Center early FY 2004 with incremental rollout beginning in FY 2005. Implementation will be in three phases:

> Phase I – Through direct access to each data base from the initial three VISN's, HRC will initially provide services by handling telephone inquiries from veterans regarding billing questions and concerns. All adjustments/inputs to veterans' account will be performed by the medical center staff.
>
> Phase II – Contingent upon development of an interface to allow seamless access to medical center data bases, first party call center services will be incrementally rolled out to additional VISN's during FY 2005.
>
> Phase III – Call agent responsibilities, to include increase or decrease adjustments, minor editing and other revenue-related services will be progressively added to the services provided by the call center.

Question 17: How do the performance standards implemented at the beginning of FY 03 measure amount of collections, gross days revenue outstanding, days to bill, etc? Do they set a minimum? A desirable range? A benchmark? A target?

Response: The Business Oversight Board (BOB) chaired by Secretary Principi and the Deputy Secretary have established a number of industry-derived performance metrics. While no minimum values have been set for the metrics, quarterly and end of year targets have been established using private industry benchmarks from HARA, the Hospital Accounts Receivable Analysis journal. Further, all Veterans Integrated Service Network (VISN) and facility directors have these standards in their performance contracts and are judged against standards set for fully successful and exceptional performance.

The metric results are rated according to a three-color scale. A VISN/facility that achieves 90% or better of its target receives a green rating. One that achieves between 70% and 89.9% of its target receives a yellow rating. And a VISN/facility that achieves less that or equal to 69.9% of its target receives a red rating. Below is a table containing the metrics, their respective HARA benchmarks, and the targets set by VHA.

	Business Oversight Board Metrics FY03			
	Collections	GDRO	Days to Bill	AR > 90 Days
HARA Benchmarks:	N/A	57 Days	9.4 Days	26.1%
Quarter 1	$356,202M	225 Days	100 Days	84.0%
Quarter 2	$746,461M	185 Days	80 Days	70.0%
Quarter 3	$1,160,721M	150 Days	65 Days	55.0%
Quarter 4	$1,575,260M	100 Days	50 Days	45.0%

Question 18: Has VA identified a system or software solution that would identify all health plans in which a veteran is enrolled?

Response: At this time, no commercial product has been identified that would provide the VA with health insurance coverage information for its entire veteran population. VA is collecting insurance eligibility responses gained through the use of HIPAA-mandated eligibility transactions and will re-use this information within the Veterans Health Administration network. This, combined with the electronic sharing of manually identified insurance, will provide an ever-growing source of third-party health insurance information, which will, in turn, support the third-party insurance billing activity. We note further that the company testifying at the May 7 hearing claiming expanded insurance verification capabilities has no installations of their system to support their claim. Further, we are concerned whether their product complies with HIPAA Privacy requirements.

Question 19: A January 2003 GAO report stated, "VA lacks a reliable estimate of uncollected dollars, and therefore does not have the basis to assess its system-wide operational effectiveness." When will the VA formulate a reliable estimate? Does VA have a methodology which can produce a reliable estimate? Explain.

Response: The GAO statement is in part accurate. Due to a combination of accounting system limitations, data and reporting deficiencies, and statutory requirements prohibiting collection from Medicare, VA does not have a totally reliable method of identifying uncollected dollars. We have, however, developed reasonably reliable methods of estimating uncollected dollars, explained as follows.

The total value for third party accounts receivable is estimated at $2.1 billion through June 2003. Thirty percent of this total is attributable to veterans with fully paying health insurance policies. Seventy percent of the total is attributable to Medicare-eligible veterans, who also have Medigap policy coverage. Since VA cannot collect from Medicare, the collection potential for this population is estimated at approximately 20% of the total accounts receivable. This 20% comes from the Medigap policies. The breakdowns are as follows:

Third Party Accounts Receivable as of June 2003

30% attributed to "fully paying policies"	$ 633,584,650
70% attributed to "Medigap policy coverage"	$1,478,364,184
Total A/R	**$2,111,948,834**

Total Collection Potential

fully paying policies (30% of total A/R)	$ 633,584,650
Medigap policy coverage (20% of total A/R)	$ 295,672,837
TOTAL COLLECTION POTENTIAL	**$ 929,257,487**

Implementation of the new Patient Financial Services System (PFSS) and related developmental efforts (Medicare Remittance Advice project) will include reporting capabilities that dramatically improve our ability for producing such data.

Question 20: In September 2001, former Under Secretary of Health Thomas Garthwaite testified that collections from the medication co-payment increase were projected to increase by $225 million in FY 2002 and $300 million in FY 2003. Did the VA meet these projections? Why or why not?

Response: The projections for FY 2002 were actually exceeded. Medication copay collections were $139 million in FY 2001 and $377 million in FY 2002, representing a $238 million increase over FY 2001. The FY 2003 projected medication copay is $651 million, a $274 million increase over FY 2002 and $512 million over FY 2001.

Question 21: The GAO reported in January 2003 that "the VA has established the Chief Business Office in VHA to direct VHA's Revenue Office and to develop a new approach for VA's collections activity." How has it been involved with MCCF reform? Please provide examples?

Response: Please see Attachment A for a list of activities in this regard.

Question 22: What initiatives beyond the improvement plan has the Chief Business Office developed and/or executed?

Response: See response to Question 3 and Attachment A, outlining the progress on the initiatives in the Revenue Improvement Plan and the new initiatives in the Revenue Action Plan.

Question 23: How much does it cost to run the Chief Business Office? What future funding has been proposed?

Response: The total funding in FY 2003 for the VACO CBO is approximately $24 million. Funding for field activities includes $335 million for the Health Administration Center in Denver, a large portion of which is for CHAMPVA; $20 million for the Health Revenue Center in Topeka; and $6 million for Health Eligibility Center in Atlanta. An increase of approximately $24 million is projected in FY 2004 for impending initiatives.

Question 24: Has the Chief Business Office developed performance measures? Please provide the Subcommittee with a complete list of successful performance measures developed by the Chief Business Office.

Response: Effective FY 2003, VHA, through the CBO, implemented industry-based performance metrics and reporting capabilities to identify and compare overall VA revenue performance. Metrics were implemented to measure revenue program performance including collections, gross days revenue outstanding (GDRO), days to bill, and AR > 90 days. For both VISN and Medical Center Directors the metrics and associated performance targets were incorporated in annual performance contracts effective FY 2003. Additional metrics associated with bills, percentage of collections to bills and cost to collect are also being reported for operational analysis purposes. As analysis and information systems enhancements occur, it is expected that the metrics will be refined and expanded over time. Further, at the end of the current fiscal year, an analysis of the success or lack thereof of each performance metric will determine whether the metric will be incorporated into FY 2004 performance contracts.

Question 25: Once the VA collects third-party funds, who gets to keep the money? The facility or the VISN? If this is not a uniform policy throughout the VA, please explain.

Response: Public Law 105-33 established the Medical Care Collection Fund, and Public Law 105-65 authorized the transfer of collections in the fund to the Medical Care Appropriation where they remain available until expended. Public Law 106-117 signed November 30, 1999, directed that collection funds be returned to the collecting facility.

Question 26: The GAO testified in 2001 about the vital importance of measuring net revenues to determine effectiveness of the program. What is the VA's cost to collect third-party revenues? After the cost of collections has been determined, what is the actual "net" amount kept? The West Palm VAMC collected $18 million last year- what was the net amount?

Response: VA computes the cost to collect by identifying the obligation amounts for each facility for revenue collection activities. This includes, but is not limited to, FTEE, travel, and contractual services. VA does not normally calculate the cost to collect third-party revenues nor the actual "net amount" kept. However, in the last year, West Palm Beach Medical Center collected $18 million. The amount of obligations for revenue collection activities was $1,138,413. Thus, the "net amount" would be approximately $16.86 million.

Question 27: The GAO testified that the VA indicated in August 2002 that 20 hospitals were still working on a step required to transmit bills to all payers. How many hospitals are still working on electronic billing and how many have full functioning electronic billing?

Response: Electronic claims are generated from all VHA facilities through a contracted clearinghouse (WebMD) for transmittal to health insurance companies. WebMD, in turn, submits electronically to those payers who accept electronic claims. If the payer cannot accept claims electronically, WebMD forwards a paper claim. All VHA facilities have implemented electronic claims for those plans that are electronically reachable through WebMD, with additional qualifiers with regard to the Blues Plans. Currently the Blue Cross Blue Shield plans as a group have more idiosyncratic or non-standard electronic billing requirements than most commercial health plans. Further, most health plans do not currently accept electronic secondary claims. When HIPAA electronic transactions standards go into effect on October 16, 2003, successful submission of electronic claims to individual Blue plans should become attainable; likewise, an expanded number of payers is expected to accept electronic submission of secondary claims. Today, all but ten VHA facilities are either successfully electronically submitting claims to their respective Blues Plan or are actively testing these transactions.

Question 28: On page 212 of the IG Audit of VA consolidated financial statements for FY 2002 and 2001, it cites a memo sent by Under Secretary Roswell to all VHA facilities directing them to contract out all aged accounts receivables over 60 days old

to a collection agency. This memo further directs that all facilities report back on actions being taken to implement the directive to the network chief financial officer within 60 days old to a collection agency. This memo further directs that all facilities report back on actions being taken to implement the directive to the network chief financial officer within 60 days. Has this been carried out? How many facilities have complied? For the record, please list facilities that have not complied and why not. How much revenue has this action generated?

Response: All networks have provided status on contracting out at 60 days in response to the May 2002 memorandum from Dr. Roswell. A list of facilities which have and have not complied with contracting out accounts receivable greater than 60 days is provided in Attachment C.

There are presently a number of contractors working on accounts receivable follow-up within VHA. Many VA facilities have a contract with Transworld Incorporated (TSI), which receives a flat rate per follow-up letter ($4.75), sent at varying intervals from the date the account is established. The majority of other contracts are based on a percentage paid to the vendor of the amount collected. In general, the older an account is from the date the bill is established, the greater the percentage of recovery paid to the vendor. The variety of contracts and terms varies considerably by facility and network, and VA is presently in the process of developing a methodology to track recoveries nationally. However, initial survey results indicate that in the most recently completed fiscal year, VA invested $4.5 million for specific accounts receivable collection vendors and collected $60 million.

Question 29: Why isn't the pre-registration of patients carried out at every facility?

Response: It is mandatory for all medical centers to use the pre-registration software and all associated processes. In March 2002, VHA issued a policy directive (2002-015) which re-emphasized the mandated use of the pre-registration and associated processes and procedures currently installed on the Veterans Health Information Systems and Technology Architecture (VistA) at Department of Veterans Affairs (VA) medical centers and Veterans Integrated Service Network (VISN) offices.

In an effort to ensure that each facility complies with this directive, VHA has required that all facilities centralize pre-registration at the VISN level by October 31, 2003. To facilitate this transition, VHA has created a Business Implementation Manager group to ensure consistency in process and procedure. The Chief Business Office has also created a response team to update existing policy and to issue revised instructions and guidance to the field on using pre-registration functionality.

Question 30: One initiative to improve collections laid out in VA's budget request for both 2003 and 2004 was the implementation of a new business plan to reconfigure the revenue collection program that includes both franchise (in-house) and contract

models. In the 2003 budget VA said, "it has made considerable progress in terms of executing the plan." The completion date for the entire project was December 2002. In its FY 2004 submission the same "new business plan" was presented with a new completion date of March 2003. Has this new business plan been fully implemented? Why did it take so long to get this project up and running? How does VA define "considerable progress?"

Response: The final report for this project was delivered in July 2003 and is currently under review. Therefore, full implementation of the plan cannot be asserted until the findings and recommendations are reviewed and evaluated. The delays associated with the startup of this project are attributed to negotiations with labor organizations and space and construction startup activities needed to house re-configured consolidated units. As indicated in the Interim Report, because of these delays, the evaluation portion of the project was extended in order to allow for a full twelve-month period of assessment.

CONGRESSMAN BOOZMAN TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Representative Boozman, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
May 7, 2003

Hearing on VA's Progress on Third Party Collections

Question 1: Would it be beneficial to certify coders and increase their salary? In your opinion, will this help eliminate error and promote effective and efficient coding by the VA?

Response: Yes, it would be beneficial to Veterans Health Administration (VHA) to hire more credentialed coders and to recognize the skills required to obtain credentials with higher compensation. Requiring VA medical centers to employ only credentialed coders would improve coding proficiency and help reduce coding error. This position is supported by numerous audit recommendations from within and external to VA (PriceWaterhouseCoopers, United Audit Systems Inc., and Rainbow Technology/First Consulting Group, and the OIG).

Accurate coding requires training and education in order to understand and apply coding guidelines and criteria. Since the billing and insurance process is intricately tied to coding and abstracting healthcare data, credentialed staff are the industry standard in the private sector and compensation is commensurate with credentials. In the VA, this is not the case. The average annual salary for credentialed coders in VA as of January 2002 was $36,500, while private sector salaries for credentialed coders ranged from $40,000 to $47,500. Current Office of Personnel Management classification standards do not recognize credentials, and that makes it impossible to formally require credentials and remunerate accordingly. To help alleviate this situation, VA has developed a legislative proposal that would enhance the Department's flexibility in hiring credentialed coders (Medical Records Technicians). This proposal is under consideration within the Administration.

VA has also published guidance to field facilities on recruitment and retention avenues available and provided examples of selection and quality factors that can be used to recruit credentialed staff. VA has also initiated a variety of on a local and national level to address the shortage of skilled coders. These include the following:

- establishment of Upward Mobility training programs to train existing staff;
- development of liaisons with educational institutions who provide coding programs;
- recruitment of coders in geographic areas with available coders to help those with critical shortages;

- training and support of current coding staff through education (satellites, web-based learning) and in-house assistance (VHA Coding Council and website inventory of issues and guidance;
- attention to life-style and employee satisfaction such as flexible tours and allowing coders to work from home;
- requiring the use of encoders and claims analyzers to assist with quality coding and submission of clean bills;
- distribution of the recommended scope of work of coders and expected accuracy and production standards;
- requiring the use of electronic encounter forms as of October 1, 2003, to assist clinicians with correct code selection; and
- establishment of a task group to improve recruitment efforts to include advertising campaigns, mail-outs, and presence at job fairs.

Shortage of coders is not just a VA issue. The American Academy of Professional Coders reports that 18% of all medical coding positions are vacant; that 10,000 new positions will be created each year; and that job prospects for formally trained coders will increase 36 percent or more through 2010. The Department of Labor attributes the greater demand on increased scrutiny by third party payors, regulators, courts and consumers. The VHA Fiscal Year 2003-2007 Workforce Succession Strategic Plan identifies certified medical record technicians as one of the top ten mission critical occupations.

Attachment A – Response to Buyer Question 3

The following objectives have been established to complement the improvement actions contained in the 2001 Revenue Improvement Plan. While some of the targeted improvements originated in Revenue Improvement Plan, others are new. All objectives are now classified as immediate (six to 12 months from CBO inception), mid-term (12 to 18 months out) and long-term (18 months and beyond).

Immediate Improvement Strategies: 6-12 months

The following are targeted for implementation between July 2002 and June 2003. Several of the initiatives have been achieved.

Performance Metrics – (Completed/On going) Effective FY 2003, the CBO implemented industry based performance metrics and reporting capabilities to identify and compare overall VA revenue performance. Metrics were implemented to measure revenue program performance including collections, gross days revenue outstanding (GDRO), days to bill, and AR > 90 days. For both VISN and Medical Center Directors the metrics and associated performance targets were incorporated in annual performance contracts effective FY 2003. Additional metrics associated with bills, percentage of collections to bills and cost to collect are also being reported for operational analysis purposes. As analysis and information systems enhancements occur it is expected that the metrics will be refined, improved and expanded over time.

Accounts Receivable Follow-up – (Completed/On going) Outsourcing of accounts receivable follow-up was originally identified as Action Item 20 in the Revenue Improvement Plan. In May 2002, the Under Secretary for Health (USH) issued a memo directing referral of outstanding accounts receivable > 60 days to AR contract entities. (Previously, facilities outsourced receivables > 90 days.) The USH recognized that reduced referral time would result in faster reimbursement while allowing staff to focus on other revenue related activities. As a result, the outstanding AR balance has decreased, despite an increase in the number of bills generated.

Expanded Available Contract Support –(Completed/On going) As proposed in Revenue Improvement Plan Action Item 20, VA established several national and local contracts for outsourcing collections on past-due accounts and insurance collections, as well as services for insurance identification and verification and coding. Currently there are in excess of 70 various contract vehicles available for use within VA. VISNs and Medical Centers have been encouraged to utilize these contracts whenever necessary to improve revenue performance.

Health Revenue Center – In an effort to leverage the skills and capabilities of the former Shared Services Center, in Topeka, KS, the CBO upon inheriting the

operation (June 2002) established the Health Revenue Center (HRC) to pilot regionalization of centralized revenue support activities. To date, HRC efforts have generated an additional $6M in collections attributed to the following initiatives:

- Pre-registration Pilot- (Completed/On Going) The HRC is providing centralized pre-registration services for VISN 11. As of the end of March 2003, the HRC made over 246,000 pre-registration calls to scheduled patients to verify their demographic and insurance information. Between May 2002 and February 2003, the HRC identified over 23,000 new insurance policies, resulting in an additional $4.5M in collections.

- AR Management Pilot – (Completed/On Going) The HRC is providing AR follow-up services for VISN 15 for aged accounts receivable. Contract representatives were engaged to train HRC personnel on proper AR management modeling private sector best practices. Between November 2002 and February 2003, the HRC processed 23,000 cases, of which 16,000 were closed as uncollectable and 7,000 were collected for a total of $1.2M.

- Hartford/USAA Settlement - (Completed/On Going) The HRC has been designated as the national processing center for refund claims related to the settlement between VA and Hartford/USAA insurance companies. Under this settlement, the two companies have paid VA a total of $11.2M (placed in an escrow account at the HRC) to settle claims for care rendered to their veteran policyholders between January 1, 1995 and December 31, 2001. The agreement requires that funds first be utilized to refund payments made by veteran policyholders for first party debt prior to being used by VA for any other purpose, and that each veteran make a claim in writing within one year to the VA for refund. A major communication effort was undertaken to ensure veterans were aware of the potential refunds.

Expedited Development of Electronic Data Interchange – Development of Electronic Data Interchange (EDI) for Insurance Claims (hospital and physician services) has been expedited to position VHA to meet HIPAA deadlines (October 2003). Initial e-Claims software is operational at all VA facilities, and over five million electronic claims have been generated as of June 2003. This software has reduced payment receipt times from those health plans that are positioned to accept electronic claims. For end-to-end electronic claims, payment cycles are reduced from 30 days to 10-14 days, and in some instances as little as five days. In addition, e-claims have resulted in significantly reduced error rates due to the automation of known payer edits.

Educational Support – In response to Revenue Improvement Plan Action Item 4, VA has made revenue training of front-line staff a priority by undertaking numerous education programs to increase awareness of revenue cycle processes. Working with

VA's Employee Education System (EES), the CBO is developing education programs for core revenue business processes including Intake, Registration, Insurance Identification and Verification, Documentation, Billing, AR Management, Coding, Utilization Review (UR), Provider Education, HIPAA/Privacy initiatives, and Health Information Management (HIM). Recognizing that training programs provide a solid educational foundation for VA staff, and foster continued growth and development while supporting VA wide implementation of industry best practices, staff training requirements have also been incorporated into VISN and Medical Center Directors' performance contracts. Training utilities include web-based courses, educational materials, and satellite broadcasts, some of which are detailed as follows:

- HIM initiated a monthly satellite broadcast series in July 1999 in which topics related to coding, billing and documentation are addressed. The broadcasts, which continue to date, consist of presentations delivered by industry experts.

- HIM focused on coder certification and web-based training curriculum, and worked with VA Employee Education System to initiate an internet-based coding curriculum that provides a complete coding training program. VHA currently has over 4,000 employees (coders and non-coders) enrolled in this program.

- A clinician education program was developed to increase awareness among physicians and other clinical staff on the importance of documentation, coding and record maintenance. Further detail on this program is provided in an update to Revenue Improvement Plan Action Item 10, discussed later.

- Web-based courses addressing UR requirements are also under development to facilitate education of clinicians and UR staff on related processes and issues.

- Training programs are being developed to prepare clerical staff to become certified as either a Medical Billing or Accounts Receivable Specialist. It is the intent of the CBO to have all Billing, AR, Coding, and UR staffs participate in certification programs.

Coding Improvement Initiatives – While pursuing longer-term changes in hiring practices and increased salaries to obtain credentialed coders, HIM has proposed centralized coding pools in two VISNs. HIM is also working on streamlining coding efficiency by implementing point of care coding at Outpatient Clinics and developing a Charge Description Master that will eliminate the review and coding of non-billable events. A CDM is also incorporated into the PFSS conceptual solution. These initiatives also contribute to the completion of Revenue Improvement Plan Action Item 13 regarding the development of a Coding Staffing Plan.

Physician Documentation and Record Completion – Some of VA's key challenges in the revenue cycle center around insufficient and/or inconsistent documentation of patient encounters. Inadequate records account for a significant amount of lost revenue. In response to Revenue Improvement Plan Action Items 9 and 11 recommending the use of electronic medical records, VA initially mandated utilization of electronic medical records (CPRS) as well as the use of automated claims analyzer and encoder tools in December 2001. Policy was reissued in May 2003 by the Under Secretary in a memorandum sent to all field stations. VA also developed electronic encounter forms and documentation templates that were released for general use in October 2002. Additional details regarding these efforts are provided in the update to Revenue Improvement Plan Action Item 11, later in this document.

Rates/Charges Publication and Updates – VHA through the CBO is streamlining processes for updating rates charged to insurers consistent with industry market rates for similar services. Reasonable Charges Version 1.4 published in the Federal Register, 4/29/03, updates rates to 2003 levels and adds charges for new diagnostic/procedural codes. Reasonable Charges Version 2.0 is under development and will make a number of changes to the Reasonable Charges rates.

Mid-Term Improvement Strategies: 12-18 months

The following mid-term improvement initiatives are targeted for implementation between July 2003 and December 2004.

Payer Relationship Management Improvements – Recognizing the importance of AR Payment and Denial management (industry journals cite payer relations and denials management competencies as critical to revenue success), the CBO is focused on developing capabilities for improving payer relationships and implementing a formal AR, Payment and Denial Management Program estimated to represent an annualized return of $200M. The program will establish formal Denial Management capabilities at the facility/VISN level and require establishment of audit-appeal business processes and claims development quality controls. The program will leverage technology such as the use of electronic Explanation of Benefits (EOB) forms to manage denials quickly and efficiently. The development of this program also includes the review of all managed care contracts and formal tracking of under payments and late payments. The appeal process and detailed documentation will be available in October 2003 and VISN denial databases will be established by the end of the 2003 calendar year.

Effective October 2003, the CBO in collaboration with VHA's Office of Quality Management is developing policies mandating pre-certification, continued stay review and procedural authorization for all health insured veterans consistent with payer requirements. VA is also establishing standard UR procedures and will have

dedicated "clinical" UR staff at every facility beginning in October 2003. In its first "payer relations test case" the CBO has been working closely with the American Association of Retired Persons (AARP) to identify improvements to billing processes and develop a mutually productive working relationship. Preliminary outcomes have resulted in VA claims being removed from a routine secondary audit process as a result of improved claim quality.

Electronic Medicare Remittance Advice (e-MRA) – Dedicated resources were assigned to support the joint VA/Centers for Medicare and Medicaid Services (CMS) MRA Project in February 2003. While portions of the software have been tested, active development continues with a target completion date of November 2003. The e-MRA project will provide payers with Medicare supplemental claims that identify deductible and coinsurance amounts that Medicare supplemental insurers will use to determine reimbursements to VA for health care services provided to veterans. In addition, VA's ability to reliably identify accounts receivable balances will be greatly enhanced.

Insurance Lockbox – The CBO is developing e-payments business and software solutions (with PNC Bank and WebMD) to electronically receive and process remittance advices from health plans and the associated payments. These electronic transaction processes will provide automated tools to assist field staff in posting payments and standardize adjustment reason codes to assist in Accounts Receivable management. They will also streamline revenue posting and AR closeout through the use of Electronic Remittance Advices and e-payments. While HIPAA does not mandate electronic payments, VA facilities will have the capability to receive them. The target completion date for this project is November 2003.

e-Claims – Action is underway to enhance existing software to auto-process electronic claims for hospital and physician services and address stringent requirements required by certain Blue Cross and/or Blue Shield plans. Electronic transmission of claims will allow for faster payment, reduced GDRO and increased billing productivity. The upgrades will also accommodate the February and March 2003 refinements of the HIPAA Electronic Transactions Final Rule. The target completion date for this project is November 2003.

Software Enhancements – The 2001 Revenue Improvement Plan identified the need to improve the charge capture process (Action Item 19). Related efforts identified that existing VistA clinical applications do not collect episode specific treatment data required for billing purposes. That missing data often results in incorrect, incomplete or rejected bills. A formal study completed in March 2002 estimated that VHA was foregoing $50 million in revenue for inpatient professional fees. VA generates the majority of its revenue from outpatient services which indicates that a substantial increase in revenue, potentially in excess of $100M per

year, could result from the implementation of these clinical application software enhancements.

The CBO has finalized identification of essential data elements in the existing VistA legacy clinical applications and action is being taken to capture (and require input of) that data, which will dramatically improve billing accuracy and collections. Thus, VistA clinical applications will be enhanced to collect and store all relevant data required to bill a product or service, and to recognize these products or services as potential billable events. The near term collection of this data in existing applications will yield immediate revenue improvements and ultimately support the PFSS effort. Necessary system enhancements will be completed for testing by September 2003, and available for VHA-wide release in November 2003.

Centralized Enrollment Information – The VHA Health Eligibility Center is redesigning the HEC database to provide enhanced eligibility and enrollment functionality to improve data quality and sharing of core veteran information. The improved system will also provide the necessary performance, reliability and security for accessing and storing federal tax information. A single VHA enrollment database, targeted for deployment in December 2003, will also provide "register once" capability and consistent/reliable eligibility information across VHA

VHA/VBA Service Connection Information Exchange Improvements – To support accurate enrollment prioritization (and appropriately determine which veterans should be billed or charged co-payments for care) CBO staff working in conjunction with VBA staff are actively pursuing an enhanced VBA/VHA data sharing solution. This initiative is focused on automating current VBA/VHA compensation and award data sharing with an initial focus on expanded access to veterans' service-connected disability ratings information. Action has been taken to improve the availability of service connection (SC) disability information for veterans with more than six SC disabilities (VBA Benefits Delivery Network disability display is limited to six SC conditions). VHA initially identified 81,275 cases known to have greater than six SC disabilities. Matching these cases to the VBA Veterans Information Tracking Adjudication Log (VITAL) database enabled VHA to increase the number of SC disabilities from six to nine. As a result of this effort, VHA display of SC disabilities was enhanced for 66,425 veterans: 20,521 with seven SC disabilities, 14,856 with eight SC disabilities, and 31,048 with nine disabilities displayed (though these cases could have more than 9 SC disabilities).

Electronic Insurance Identification and Verification – It is estimated that an additional $40 million in revenue can be collected for each additional percentage of identified health insurance coverage. In response, VA is developing business and software solutions with WebMD and other health care clearinghouses to automate the identification and verification of health insurance benefits. This e-IIV initiative is targeted for national implementation in November 2003.

Long-Term Improvement Strategies – 18+ months

The following long-term initiatives are targeted for implementation beginning in 2005. Several of these initiatives are already being actively pursued, with milestones established over the next several months.

Patient Financial Service System – The Patient Financial Services System (PFSS) project will result in the implementation of a commercial-off-the-shelf (COTS) health care billing and accounts receivable software system to replace the legacy VistA IB and AR applications. The project will also include the implementation of business process improvements based on commercial best practices, centralization of business processes, and potential outsourcing initiatives. An updated status of PFSS is provided in response to questions 15 –17.

Regional Processing Centers – The CBO is pursuing the establishment of regional service centers throughout VHA to centralize revenue cycle business processes. Included in this effort is the establishment of a National Revenue Call Center that will provide centralized call center services for veterans with questions concerning co-payment bills. The call center will increase revenue by removing the customer service burden from local MCCF staff and allowing them to focus on billing and collection activities. A Benefits Call Center is also being pursued to provide a central call center for veterans' questions about eligibility for health care and other topics.

System Adaptability/Industry Compatible Technology – The CBO in partnership with the Department CIO is focused on ensuring that the integration and or development of new technological improvements are compatible with the VA technology and processing environment. As new systems are implemented, the CBO working with the CIO will ensure integration with the overall VA enterprise architecture.

Organizational Evolution – Working in concert with field-based staff, the CBO is pursuing multiple business process changes to improve revenue and mirror commercial best practices. These process improvements will include VA-wide assignment of responsibility/accountability, more stringent performance measures, incentives, organizational change management and standardization and definition of performance driven expectations.

Coding Staffing Plan – Development of a Staffing Plan for Coding was originally detailed in Revenue Improvement Plan Action Item 13, which recommended development of a comprehensive staffing plan to address known coding deficiencies. The Office of Health Information Management (HIM) completed an extensive study on coding staffing issues within VA and researched coding staffing practices within the private sector. Key findings revealed that 77% of VA sites have coding

vacancies; 41% of VA's existing coders will retire in the next five years; credentialing is not currently required within VA; and that there is a significant difference between the salaries offered in the private sector versus VA. In response, and in addition to the internal training programs discussed above, HIM has formulated a coding staffing plan to address these issues. The plan proposes the Office of Personnel Management modify current requirements to permit direct hiring authority for credentialed coders in order to attract qualified coding staff and calls for the establishment of industry-compatible salaries.

e-Outpatient Pharmacy and e-Dental Claims – Software upgrades are being developed for Outpatient Pharmacy Claims and are planned for Dental Claims. While prescription and dental benefits are minimal, modest additional revenue is expected as a result of these initiatives. Implementation of e-Pharmacy Claims is targeted for completion by April 2004 and the e-Dental Claims Project will be initiated by January 2004.

e-Health Care Services Review and Response – Software upgrades are planned to add new functionality to standardize and automate the health care service review processes. This new functionality will automate the current manual and cumbersome business process and streamline VHA's operations, thereby contributing to increased efficiency and revenue. This project is targeted for initiation by January 2004.

e-Status Messaging – The CBO will upgrade claims status messaging functionality in e-Claims software to attain full HIPAA compliance. This functionality is also expected to improve AR follow-up by quickly identifying "standardized" reasons for denials or suspended claims. This project is targeted for initiation by January 2004.

e-Claims Attachment Pilot – VA is expecting the Final Rule for Claims Attachment this fiscal year. In response to the rule, VHA must develop the capability to electronically receive requests from health plans for additional claim documentation and to respond to the requests electronically. The ability to receive and respond to requests electronically will expedite the claims processing in those situations where payers require additional documentation to determine payment. This project is targeted for initiation by January 2004.

e-Recoupment for Fee Claims Paid – The CBO will upgrade VHA's automated infrastructure to electronically share reimbursable claims data paid through the Fee program to the provider billing system for recoupment. This functionality will significantly improve VHA's ability to identify and bill for Fee Program services paid to community providers, resulting in additional claims and increased collections. This project is targeted for initiation by January 2004.

The information below provides an itemized update and status of the original 24 individual Revenue Improvement Plan Action Items.

1. Mandate pre-registration of veterans – Complete
VHA directive 2002-015 issued March 8, 2002, mandated the use of the pre-registration software by medical centers.

2. Define standards for complete and accurate data capture – Complete
The CBO is in the process of developing a directive to identify required data fields in the VistA software to complement the registration process.

This Action Item is also being pursued through PFSS and VHA CIO Billing Aware initiatives. PFSS teams developing system requirements and process flows are determining data elements required by a billing system. CBO and CIO staffs have identified required data elements and are currently developing VistA enhancements, as detailed in the mid-term improvement strategies section under "Software Enhancements." These system enhancements will serve to immediately improve data capture quality and ultimately support the efficacy of the PFSS solution.

The PFSS initiative includes the design of system and process flows that will ensure more accurate data capture, as well as implementation of standard data collection and capture processes across VA. Additional information on PFSS is provided in the responses to questions 15 – 17 below.

3. Implement Veteran Education Program – Complete
VHA has developed a series of posters, pamphlets and other informational materials for veterans regarding the importance of insurance identification, co-payment requirements and other regulated billing changes. Veteran educational materials were distributed with patient statements released in December 2001, January 2002, and February 2002 and will be reissued on a periodic basis.

4. Implement Employee Education Program – Complete/On going
Employee education programs are being pursued through the Educational Support initiative. Working with VA's Employee Education System (EES), the CBO is developing education programs for core revenue business processes including Intake, Registration, Insurance Identification and Verification, Documentation, Billing, AR Management, Coding, Utilization Review (UR), Provider Education, HIPAA/Privacy initiatives, and Health Information Management (HIM). Recognizing that training programs provide a solid educational foundation for VA staff, and foster continued growth and development while supporting VA wide implementation of industry best practices, staff training requirements have also been incorporated into VISN and Medical Center Directors' performance contracts. Training utilities include web-based courses, educational materials, and satellite broadcasts. This action item is labeled "in process" as it must be perpetually ongoing.

5. Implement electronic insurance identification and verification – On Target

This Action Item is now incorporated in the CBO e-Insurance Identification and Verification (e-IIV) project and is an essential component of the PFSS project. The CBO is also pursuing e-IIV as part of the HIPAA mandated e-Business initiatives. E-IIV is on schedule for national implementation in November 2003. The PFSS conceptual solution includes electronic insurance identification and verification through the use of COTS products. Several VA medical centers are currently using electronic insurance verification tools that are serving as interim solutions while the national solution is developed and implemented.

6. Consolidate insurance information at the enterprise level – On Target.
This Action Item is now being pursued through the PFSS and e-IIV projects. The PFSS conceptual solution includes an enterprise Insurance Master File. The e-IIV project is scheduled for release in November 2003. The consolidation of insurance information across the entire VA will occur in FY 2005.

7. Develop an Employer Master File – Cancelled
After analysis, the field-based workgroup assigned to this action item determined an Employer Master File database would not be cost effective. The team instead recommended that collection of veterans' employer and insurance data become a mandatory element of all patient registrations. Implementation of this recommendation would provide all of the benefits of an Employer Master File without the development expense. See item 2 above.

The PFSS conceptual solution provides more comprehensive pre-registration processes including collection and verification of veterans' employer and insurance data during the patient intake process.

8. Enforce national documentation policy –On Going
The Health Information Management and Health Records handbook is in the last stages of concurrence. On July 17, 2003, final edits were received from General Counsel. All edits will be incorporated into the final document. An exact date for publishing has not yet been set.

9. Mandate use of electronic medical records (CPRS) –On Going
In January 2002 the Under Secretary for Health mandated full implementation of CPRS, with performance measures, by 2004.

10. Develop national clinical education program –On Going
Representatives from Health Information Management worked with EES to develop and distribute a comprehensive clinical education toolkit. The initiative included: posters and laminated pocket reference cards with CPT codes and CPT evaluation and management service selection guidelines, videos, presentations for use at clinical staff meetings and quick reference guides. Materials have also been posted on the VA Physician Education website. A commercial web based training program was selected by the Health Information Management Program and purchased by the Employee Education System. There are currently over 4,000 VHA staff enrolled in this training.

11. Develop and mandate use of electronic encounter form and documentation templates – Complete
Electronic encounter forms were developed and released for Mental Health, Primary Care, Gastroenterology, Urology, Pulmonary, Podiatry, Eye, Cardiology (2 forms), General Surgery, Orthopedics, Hematology/Oncology, Physical Medicine and Rehabilitation, and Dermatology.

Primary Care and Mental Health templates were posted to the HIM web site in October 2002. In addition standardized documentation templates for eye care, surgical care, attending notes, acute/and extended care and history and physical have also been posted. Development of additional encounter forms is ongoing and national utilization of the forms was mandated in VHA directive 2003-012 effective nationally October 1, 2003.

12. Develop and implement documentation tracking system – On Target
This solution is embedded in a number of projects including Billing Aware and CPRS Re-engineering. Claims Analyzers provide coders and billers immediate access to claims requiring edit reviews. An initiative to develop an easier method for clinicians to appropriately associate current treatment to service-connected conditions and ensure that encounters are being appropriately billed is under development. The initiative to develop centralized coder pools includes a strategy for exploring the use of emerging software utilities to track and improve workflow. Additional vendor software enhancements that will facilitate the identification of billable encounters and reduce billing production time are also being explored. With regard to Document Tracking---This item has been embedded in a number of current projects, including Billing Aware software functionality upgrades to make the clinical packages more billing aware and CPRS Re-engineering. CPRS re-engineering will include many additional reporting features that will notify clinicians of missing or needed documentation. There are initiatives in discussion to provide clinicians with electronic functionality that to assist with note writing, coding, and functionality that will improve workflow of coders. Other vendor software enhancements already available assist

with improving the process to identify billable encounters and claims that require manual review prior to billing, therefore reducing time to bill.

13. Develop staffing plan for coding resource – Complete
Health Information Management submitted an initial proposal in October 2002. A separate document was released to the field communicating coding standards as a result of this project. Recommendations relative to recruitment and retention issues are being pursued at this time. While the actual development of the Staffing Plan is complete, it is important to note that actual implementation of the plan and pursuit of its goals are still being pursued.

14. Mandate use of encoder software – Complete
The ADUSH issued a memo to Network Directors requiring the use of encoder software in December 2001. All sites now have encoder software installed. Use of electronic claims analyzers was endorsed in a network memorandum to the field in May 2002. Currently most medical centers are using electronic claims analyzers and encoder tools in coding and billing processes. However, in the same memo discussed in items 9 and 11, the Under Secretary for Health mandated utilization of encoders and claims scrubbers at all facilities.

15. Develop national standard for laboratory, radiology, and other ancillary test names and corresponding CPT codes – On Target
CBO and VHA CIO representatives identified clinical application deficiencies and issues related to lack of standardization and corresponding CPT codes. This Action Item is being resolved through the implementation of PFSS, as it will incorporate use of standard CPT codes. COTS billing products are equipped with standard AMA CPT codes, and COTS vendors automatically release code updates for their products as soon as they are available from AMA.

16. Mandate minimum access policy to VistA ancillary packages – Complete
Previously, coders and billers lacked access to many of the clinical ancillary applications in which potential billable episodes are captured. As a result, numerous billable episodes were unidentified, resulting in lost revenue. Providing billing staff with access to VistA clinical applications would increase identification of billable events and claims accuracy. Therefore, a memorandum was issued to the field mandating minimum access policy to VistA ancillary packages in May 2002.

17. Complete implementation of the EDI Billing and MRA projects – On Target
This Action Item is being pursued through the CBO's e-MRA, e-Payments (third-party lockbox) and e-Rx claims projects detailed below:

e-Claims – Initial e-Claims software is operational at all VA facilities, and over four million electronic claims have been generated as of April 2003. This software has reduced payment receipt times from those health plans that are positioned to accept

electronic claims. For end-to-end electronic claims, payment cycles are reduced from 30 days to 10-14 days, and in some instances as little as five days. In addition, e-claims have resulted in significantly reduced error rates due to the automation of known payer edits. Action is underway to enhance existing software to auto-process electronic claims for hospital and physician services and address stringent requirements required by certain Blue Cross and/or Blue Shield plans. Electronic transmission of claims will allow for faster payment, reduced GDRO and increased billing productivity. The upgrades will also accommodate the February and March 2003 refinements of the HIPAA Electronic Transactions Final Rule. The target completion date for this project is November 2003.

Electronic Medicare Remittance Advice (e-MRA) – Dedicated resources were assigned to support the joint VA/Centers for Medicare and Medicaid Services (CMS) MRA Project in February 2003. While portions of the software have been tested, active development continues with a target completion date of November 2003. The e-MRA project will provide payers with Medicare supplemental claims that identify deductible and coinsurance amounts that Medicare supplemental insurers will use to determine reimbursements to VA for health care services provided to veterans. In addition, VA's ability to reliably identify accounts receivable balances will be greatly enhanced.

Insurance Lockbox – The CBO is developing e-payments business and software solutions (with PNC Bank and WebMD) to electronically receive and process remittance advices from health plans and the associated payments. These electronic transaction processes will provide automated tools to assist field staff in posting payments and standardize adjustment reason codes to assist in Accounts Receivable management. They will also streamline revenue posting and AR closeout through the use of Electronic Remittance Advices and e-payments. While HIPAA does not mandate electronic payments, VA facilities will have the capability to receive them. The target completion date for this project is November 2003.

18. Implement "claims analyzer" tools - Complete

The ADUSH issued a memo to Network Directors mandating used of claims scrubber software in December 2001. In May 2002, VHA leadership encouraged use of specific tools and VA's agreement to support interfaces in May 2002. In May 2002, an Ingenix software interface was released to the field. Several VISNs have implemented and are using either the Quadramed or Ingenix software. Again, in his memo released in April 2003, the Under Secretary has reaffirmed this as a mandated process requirement.

19. Improve the charge capture process – On Target

This Action Item is now being pursued through the Billing Aware (Software Enhancements) and PFSS projects identified in the Mid-Term and Long-Term Improvement Strategies. The VHA CIO Billing Aware teams completed Systems

Requirements Specifications for eight VistA clinical applications and are in the process of implementing required improvements. The enhanced applications will be implemented across the VA by November 2003.

20. Consolidate/outsource VHA "3rd Party" Accounts Receivable follow-up – Complete/On Going

This Action Item is now being pursued through the "Accounts Receivable Follow-Up" and "Expanded Contract Support" initiatives detailed in the Immediate Improvement Strategies section.

21. Develop utilization review (UR) program –On Target

A new UR policy calling for assessment of dedicated clinical professionals to UR is in concurrence and once approved will become formal policy. The Utilization Review team is now working with VA Employee Education System to finalize four web-based modules to provide training materials for Utilization Review staff.

22. Request VA General Counsel more aggressively pursue "referred" 3rd party Accounts Receivable –On going

A formal request for General Counsel support of accounts receivable follow up was initially submitted in May 2002. Since then, CBO and OGC have established an ongoing dialogue and working group to address revenue issues. As a result, CBO and OGC have initiated several improvements, including development of revised reasons for referral, software changes to the electronic referral system between the MCCF staff and Regional Counsel offices; a denials code management program; and a strategy to address aging receivables.

23. Implement insurance payment and remittance program – On Target

This Action Item is being pursued through the CBO's EDI Lockbox (e-Payments project) detailed in the mid-term improvement strategies section, under "EDI Lockbox". The EDI Lockbox System currently being developed will enable the electronic transmission of insurance payments and remittance advices to VHA through a contracted commercial financial institution for payment processing. Lockbox software is currently in development. Software integration and user acceptance testing started in January 2003. Training materials are being refined. E-Payments is currently on schedule for a November 2003 implementation.

24. Implement Accounts Receivable management software – On Target

This Action Item is being pursued through the PFSS project. PFSS will provide COTS AR management functionality that incorporates private sector best practices for the processing and management of Accounts Receivable. This functionality will be installed in the VA Health Care Network of Ohio (VISN 10) by September 2004.

Attachment B – Response to Buyer Question 14

VHA Rank of Facilities By Percent of Collections to Goals Using Medicare Unadjusted Data for June 2003

Sta No	Facility Name	Jun-03
593	Las Vegas	127%
618	Minneapolis	125%
561	New Jersey HCS	124%
459	Honolulu	120%
666	Sheridan	119%
668	Spokane	119%
600	Long Beach	117%
605	Loma Linda	117%
619	CAVHCS(Montgomery)	117%
538	Chillocothe	116%
589	Kansas City, MO	114%
557	Dublin	112%
552	Dayton	111%
575	Grand Junction	111%
654	Sierra Nevada HCS	110%
437	Fargo	109%
539	Cincinnatti	109%
623	Muskogee	108%
436	Fort Harrison	108%
516	Bay Pines	107%
438	Sioux Falls	107%
664	San Diego	106%
667	Shreveport	106%
544	Columbia	106%
612	No. CA HCS	106%
656	St. Cloud	106%
636	Nebraska/W. Iowa	106%
598	Little Rock	106%
660	Salt Lake City	106%
640	Palo Alto HCS	106%
757	Columbus	105%
662	San Francisco VAMC	105%
534	Charleston	105%
657	St. Louis, MO	105%
549	N Texas VAHCS	104%
541	Cleveland	104%
402	Togus	103%
564	Fayetteville AR	103%

VHA Rank of Facilities By Percent of Collections to Goals Using Medicare Adjusted Data for June 2003

Sta No	Facility Name	Jun-03
618	Minneapolis	117%
593	Las Vegas	116%
561	New Jersey HCS	114%
600	Long Beach	113%
666	Sheridan	106%
619	CAVHCS(Montgomery)	106%
668	Spokane	105%
623	Muskogee	105%
589	Kansas City, MO	104%
459	Honolulu	103%
605	Loma Linda	103%
552	Dayton	103%
557	Dublin	102%
437	Fargo	102%
438	Sioux Falls	101%
654	Sierra Nevada HCS	101%
636	Nebraska/W. Iowa	100%
564	Fayetteville AR	100%
667	Shreveport	99%
436	Fort Harrison	99%
516	Bay Pines	99%
575	Grand Junction	99%
662	San Francisco VAMC	98%
549	N Texas VAHCS	98%
581	Huntington	98%
657	St. Louis, MO	97%
660	Salt Lake City	97%
539	Cincinnatti	97%
640	Palo Alto HCS	97%
402	Togus	96%
612	No. CA HCS	96%
534	Charleston	96%
656	St. Cloud	96%
580	Houston	95%
538	Chillocothe	95%
649	N. Arizona VAHCS	95%
544	Columbia	95%
607	Madison	94%

581	Huntington	103%
570	Central CA HCS	101%
621	Mt. Home	101%
608	Manchester	101%
695	Milwaukee	101%
405	White River Jct.	101%
649	N. Arizona VAHCS	100%
518	Bedford	100%
540	Clarksburg	100%
650	Providence	100%
632	Northport	100%
585	Iron Mt	99%
603	Louisville	99%
689	Conn HCS	99%
679	Tuscaloosa	99%
586	Jackson	99%
523	Boston	99%
568	Black Hills	98%
676	Tomah	98%
613	Martinsburg	98%
607	Madison	98%
521	Birmingham	97%
692	So. Oregon Rehab	97%
578	Hines	97%
614	Memphis	97%
520	Biloxi	97%
531	Boise	96%
691	Greater Los Angeles	95%
580	Houston	95%
583	Indianapolis	95%
631	Northampton	95%
529	Butler	95%
517	Beckley	94%
556	N Chicago	94%
548	West Palm Beach	94%
503	Altoona	94%
596	Lexington	94%
535	Chicago	93%
620	Hudson Valley HCS	93%
655	Saginaw	92%
626	TN Valley	92%
558	Durham	92%
659	Salisbury	91%
637	Asheville	91%
565	Fayetteville	91%

405	White River Jct.	94%
757	Columbus	93%
621	Mt. Home	93%
521	Birmingham	92%
518	Bedford	92%
517	Beckley	92%
586	Jackson	92%
650	Providence	92%
664	San Diego	91%
568	Black Hills	90%
608	Louisville	90%
695	Milwaukee	90%
523	Boston	90%
558	Durham	90%
676	Tomah	90%
570	Central CA HCS	89%
689	Conn HCS	89%
659	Salisbury	89%
541	Cleveland	89%
679	Tuscaloosa	89%
503	Altoona	89%
585	Iron Mt	89%
583	Indianapolis	88%
565	Fayetteville	88%
608	Manchester	88%
520	Biloxi	87%
596	Lexington	87%
531	Boise	87%
578	Hines	87%
548	West Palm Beach	87%
556	N Chicago	86%
562	Erie	85%
693	Wilkes-Barre	85%
529	Butler	84%
620	Hudson Valley HCS	84%
554	Denver	84%
540	Clarksburg	84%
691	Greater Los Angeles	84%
632	Northport	83%
610	North. Indiana HCS	83%
595	Lebanon	83%
508	Atlanta	82%
653	Roseburg	82%
631	Northampton	82%
626	TN Valley	81%

610	North. Indiana HCS	91%
693	Wilkes-Barre	91%
595	Lebanon	91%
562	Erie	90%
554	Denver	90%
526	Bronx	90%
508	Atlanta	90%
460	Wilmington	89%
509	Augusta	89%
653	Roseburg	89%
550	Danville	89%
644	Phoenix VAMC	88%
673	Tampa	88%
442	Cheyenne	88%
573	North Fl/South Ga	86%
635	Oklahoma City	85%
515	Battle Creek	85%
506	Ann Arbor	85%
642	Philadelphia	85%
674	C Texas VAHCS	84%
652	Richmond	84%
646	Pittsburgh	83%
504	Amarillo VAHCS	83%
756	El Paso VAHCS	83%
502	Alexandria	83%
519	W. Texas VAHCS	83%
553	Detroit	81%
648	Portland	81%
546	Miami	81%
678	S. Arizona VAHCS	79%
542	Coatesville	79%
663	Puget Sound HCS	79%
501	New Mexico VAHCS	78%
590	Hampton	76%
528	Buffalo	75%
672	San Juan	75%
512	Baltimore	74%
671	S Texas VAHCS	71%
688	Washington DC	71%
687	Walla Walla	70%
630	NY Harbor HCS	69%
658	Salem	68%
629	New Orleans	61%
463	Anchorage	60%

652	Richmond	81%
673	Tampa	80%
573	North Fl/South Ga	79%
535	Chicago	79%
635	Oklahoma City	79%
642	Philadelphia	78%
460	Wilmington	78%
550	Danville	78%
655	Saginaw	78%
526	Bronx	78%
613	Martinsburg	77%
646	Pittsburgh	77%
644	Phoenix VAMC	77%
648	Portland	77%
502	Alexandria	76%
674	C Texas VAHCS	76%
756	El Paso VAHCS	75%
504	Amarillo VAHCS	75%
515	Battle Creek	74%
546	Miami	74%
501	New Mexico VAHCS	73%
678	S. Arizona VAHCS	73%
509	Augusta	72%
553	Detroit	71%
519	W. Texas VAHCS	71%
442	Cheyenne	71%
542	Coatesville	71%
528	Buffalo	70%
590	Hampton	70%
506	Ann Arbor	70%
663	Puget Sound HCS	69%
658	Salem	65%
688	Washington DC	63%
692	So. Oregon Rehab	63%
671	S Texas VAHCS	62%
687	Walla Walla	62%
512	Baltimore	58%
637	Asheville	58%
463	Anchorage	56%
672	San Juan	55%
629	New Orleans	49%
630	NY Harbor HCS	48%
614	Memphis	*
598	Little Rock	*

* No Obligation Data found for these sites.

Attachment C – Response to Buyer Question 28

Refer at 60 Days - Station has an Accounts Receivable and Refers Accounts when They are 60 Days Old from Date of Bill

VISN	FACILITY NAME
1	TOGUS
1	WHITE RIVER JCT
1	BEDFORD
1	MANCHESTER
1	NORTHAMPTON
2	ALBANY
2	BATH
2	BUFFALO (Int)
2	SYRACUSE
4	WILMINGTON
4	ALTOONA
4	BUTLER
4	CLARKSBURG
4	COATESVILLE
4	ERIE
4	LEBANON
4	PHILADELPHIA
4	PITTSBURGH (Int)
4	WILKES-BARRE
5	BALTIMORE (Int)
5	MARTINSBURG
5	WASHINGTON
7	ATLANTA
7	AUGUSTA
7	COLUMBIA (SC)
7	DUBLIN
7	MONTGOMERY (Int)
7	TUSCALOOSA
8	BAY PINES
8	MIAMI
8	WEST PALM BEACH
8	GAINESVILLE
8	SAN JUAN
8	TAMPA
9	HUNTINGTON

VISN	FACILITY NAME
9	LEXINGTON
9	LOUISVILLE
9	MEMPHIS
9	MOUNTAIN HOME
9	NASHVILLE (Int)
10	CLEVELAND
16	ALEXANDRIA
16	BILOXI
16	HOUSTON
16	JACKSON
16	MUSKOGEE
16	NEW ORLEANS
16	OKLAHOMA CITY
16	SHREVEPORT
18	ALBUQUERQUE
18	AMARILLO
18	BIG SPRING
18	PHOENIX
18	PRESCOTT
18	TUCSON
18	EL PASO OPC
20	SEATTLE (Int)
22	LAS VEGAS
22	LONG BEACH
22	SAN DIEGO
22	WEST LOS ANGELES(Int)

Attachment C – Response to Buyer Question 28

No Contracts- Station Does Not Use an Accounts Receivable Vendor

VISN	FACILITY
1	BOSTON (Int)
1	PROVIDENCE
1	WEST HAVEN (Int)
10	CHILLICOTHE
10	DAYTON
10	COLUMBUS OPC
16	FAYETTEVILLE (AR)
16	LITTLE ROCK
19	FORT HARRISON(Int.)
19	CHEYENNE
19	DENVER
19	FORT LYON
19	GRAND JUNCTION
19	SALT LAKE CITY
19	SHERIDAN
20	ANCHORAGE
20	BOISE
20	PORTLAND
20	ROSEBURG
20	SPOKANE
20	WALLA WALLA
20	WHITE CITY DOM

Attachment C – Response to Buyer Question 28

Refer at 60 or More Days - Facility has an Accounts Receivable Vendor and Refers Accounts at More Than 60 Days from Date of Bill

VISN	Facility
3	BRONX
3	EAST ORANGE (Int)
3	MONTROSE (Int)
3	NEW YORK (Int)
3	NORTHPORT
6	BECKLEY
6	DURHAM
6	FAYETTEVILLE (NC)
6	HAMPTON
6	ASHEVILLE
6	RICHMOND
6	SALEM
6	SALISBURY
7	BIRMINGHAM
7	CHARLESTON
10	CINCINNATI
11	ANN ARBOR
11	BATTLE CREEK
11	DANVILLE
11	ALLEN PARK
11	INDIANAPOLIS
11	MARION (IN) (Int)
11	SAGINAW
12	CHICAGO (Int)
12	NORTH CHICAGO
12	HINES
12	IRON MOUNTAIN
12	MADISON
12	TOMAH
12	MILWAUKEE
15	WICHITA
15	COLUMBIA (MO)
15	KANSAS CITY
15	MARION (IL)
15	POPLAR BLUFF
15	ST LOUIS
15	TOPEKA (Int)
17	DALLAS (Int)
17	SAN ANTONIO (Int)
17	TEMPLE (Int)

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