

GAO

Report to the Chairman, Subcommittee
on Oversight and Investigations,
Committee on Veterans' Affairs, House of
Representatives

July 2004

VA MEDICAL CENTERS

Further Operational Improvements Could Enhance Third-Party Collections



G A O

Accountability * Integrity * Reliability



Highlights of [GAO-04-739](#), a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

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

What GAO Recommends

GAO is making five recommendations to augment actions already underway to facilitate more timely billings and improve collection operations. In responding to our draft report, VA agreed with our conclusions and expressly concurred with the recommendations and reported that it is developing an action plan to implement them.

www.gao.gov/cgi-bin/getrpt?GAO-04-739.

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

VA MEDICAL CENTERS

Further Operational Improvements Could Enhance Third-Party Collections

What GAO Found

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

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

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

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Abbreviations

CBO	Chief Business Office
MCCF	Medical Care Collection Fund
OIG	Office of Inspector General
PFSS	Patient Financial Services System
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

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United States Government Accountability Office
Washington, D.C. 20548

July 19, 2004

The Honorable Steve Buyer
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) provides health care to eligible veterans through medical facilities managed by its Veterans Health Administration (VHA). Under certain circumstances, VA is authorized to collect reasonable charges from veterans' health insurance companies to offset the cost of medical care and medications for treatment of nonservice-connected conditions. Specifically, VA may bill insurance companies for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service. VA is not authorized to bill for health care conditions that result from military service, nor is it generally authorized to collect from Medicare and Medicaid. In fiscal year 2003, VA collected \$804 million in insurance payments, also known as third-party collections. These collections provided VA the largest source of revenue to supplement its \$25 billion medical care appropriation in fiscal year 2003, and they helped pay for costs associated with growing health care demands for veterans.

Over the past several years, we and the VA Office of the Inspector General (OIG) have raised concerns about VA's ability to maximize its third-party collections to enhance revenue. In September 2001, we testified that problems in VA's collection operations—such as inadequate patient intake procedures to gather insurance information, insufficient physician documentation of the specific care provided, a shortage of qualified coders, and insufficient automation—diminished VA's collections.¹ In February 2002, the VA OIG reported that VA missed billing opportunities, had billing

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).

backlogs, and did inadequate follow-up on accounts receivable in fiscal years 2000 and 2001.² In May 2003 we testified that VA had made improvements in these areas but that operational problems, such as unpaid accounts receivable, missed billing opportunities, and billing backlogs continued to limit the amount VA collects.³

In conjunction with this revenue-enhancing responsibility, you asked us to review internal control activities over third-party billings and collections at selected VHA medical centers to assess whether internal controls are now designed and implemented effectively.

To gain an understanding of VHA's policies and procedures and the related internal controls and to assess the design effectiveness of those controls, we obtained and reviewed VA and VHA directives, handbooks, and other policy guidance, and previous reports issued by VA's OIG. We also conducted interviews and walkthroughs with VHA personnel and reviewed our previous reports. To assess whether key control activities for billings and collections were effectively implemented, we used a case study approach, reviewing transaction documentation at three VA medical centers. We conducted our review from March 2004 through June 2004 in accordance with U.S. generally accepted government auditing standards.

Results in Brief

VA has continued to take actions to reduce billing times and increase third-party collections. Collections of third-party payments have increased 49 percent from \$540 million in fiscal year 2001 to \$804 million in fiscal year 2003. At the same time, at the three medical centers we visited, we found continuing weaknesses in the billings and collections processes that impair VA's ability to maximize the amount of dollars paid by third-party insurance companies. For example, the three medical centers did not always bill insurance companies in a timely manner. Medical center officials told us that inability to verify and update patients' third-party insurance, inadequate documentation to support billings, manual processes and workload continued to affect billing timeliness. For instance, we were told

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

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

that insufficient treatment documentation by physicians and other health care providers continued to cause delays in coding bills. The cumulative effect of this intertwined set of issues results in late or incomplete bills and lost revenue.

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

VA's current Revenue Action Plan (Plan) includes 16 actions designed to increase collections by improving and standardizing collections processes. Several of these actions are aimed at reducing billing times and backlogs. Specifically, medical centers are updating and verifying patients' insurance information and improving health care provider documentation. Further, hiring contractors to code and bill old cases is reducing backlogs. In addition to actions already taken, VA has several other initiatives underway. For example, VA is taking action to enable Medicare secondary insurance companies to determine the correct reimbursement amount, which will strengthen VA's position to follow-up on partial payments that it deems incorrect. However, the Plan has not yet been fully implemented. Therefore, it is too early to determine the extent to which actions in the Plan will address operational problems and increase collections.

Because the Plan does not address all facets of the operational issues, we are making five recommendations to augment those actions currently underway. In commenting on a draft of this report the Secretary of Veterans Affairs concurred with our conclusions and recommendations and reported that the department is developing an action plan to implement them. For additional information see the Agency Comments and Our Evaluation section of this report and appendix I.

Background

The Veterans' Health Care Eligibility Reform Act of 1996⁴ authorized VA to provide certain medical services not previously available to veterans with non-service connected conditions. The Balanced Budget Act of 1997⁵ authorized VA to use third-party health insurance payments to supplement its medical care appropriations. As part of VA's 1997 strategic plan, VA expected that collections from third-party payments and co-payments would cover the majority of costs of care for these veterans, some of which VA has determined to have higher incomes. For fiscal year 2002, about a quarter of VA's user population were higher income veterans.

In September 1999, VA adopted a new fee schedule, called "reasonable charges," which are itemized fees based on diagnoses and procedures.⁶ This schedule allows VA to more accurately bill for the care provided. By linking charges to the care provided, VA created new bill-processing demands—particularly in the areas of documenting care, coding that care, and processing bills per episode of care. First, VA must be prepared to provide the insurance company with supporting medical documentation for itemized charges. Second, 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. Third, VA must prepare a separate bill for each health care provider involved in the patient's care and an additional bill when a hospital facility charge applies.

To collect from health insurance companies, VA uses a four function process to manage the information needed to bill and collect third-party payments—also known as the Medical Care Collection Fund (MCCF) Revenue Cycle (see fig. 1). First, the patient intake function involves gathering insurance information and verifying that information with the insurance company as well as collecting demographic data on the veteran. Second, utilization review involves precertification of care in compliance with the veteran's insurance policy, including continued stay reviews to determine medical necessity. Third, billing functions involve properly documenting the health care provided to patients by physicians and other

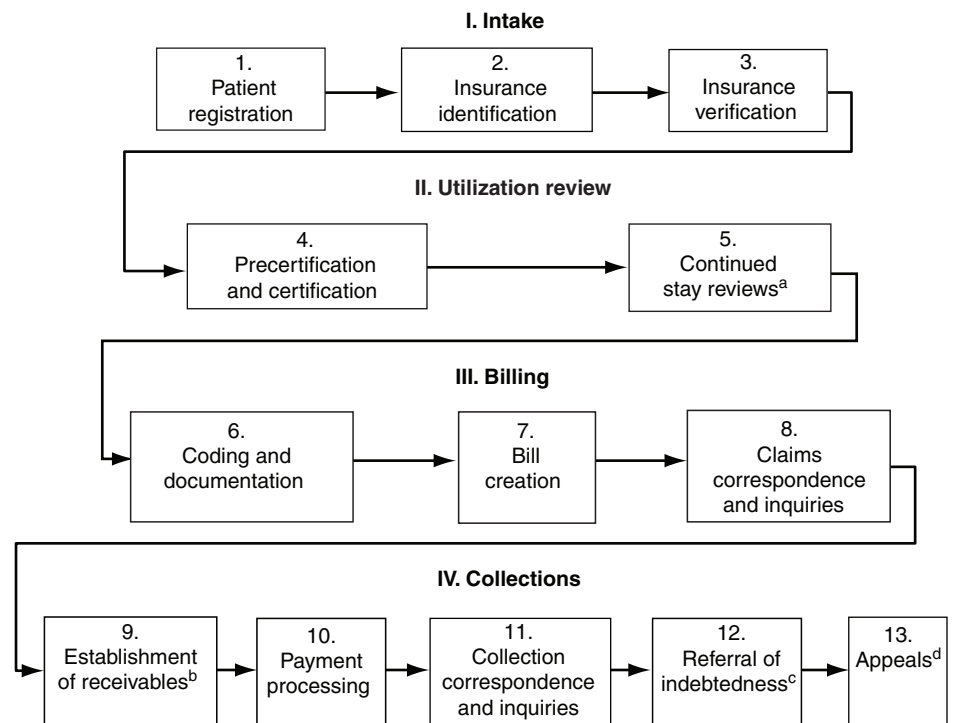
⁴ Pub. L. No. 104-262, § 101, 110 Stat. 3177, 3178 (Oct. 1996), *codified at* 38 U.S.C. § 1710.

⁵ Pub. L. No. 105-33, § 8023, 111 Stat. 251, 665 (Aug. 5, 1997), *codified at* 38 U.S.C. § 1729A.

⁶ Reasonable charges are defined as amounts that insurance companies would pay private sector health care providers in the same geographic area for the same services.

health care providers. Based on the physician documentation, the diagnoses and medical procedures performed are coded. VA then creates and sends bills to insurance companies based on the insurance and coding information obtained. And fourth, the collections or accounts receivable function includes processing payments from insurance companies and following up on outstanding or denied bills.

Figure 1: VA's MCCF Revenue Cycle for Third-Party Collections



Source: VA.

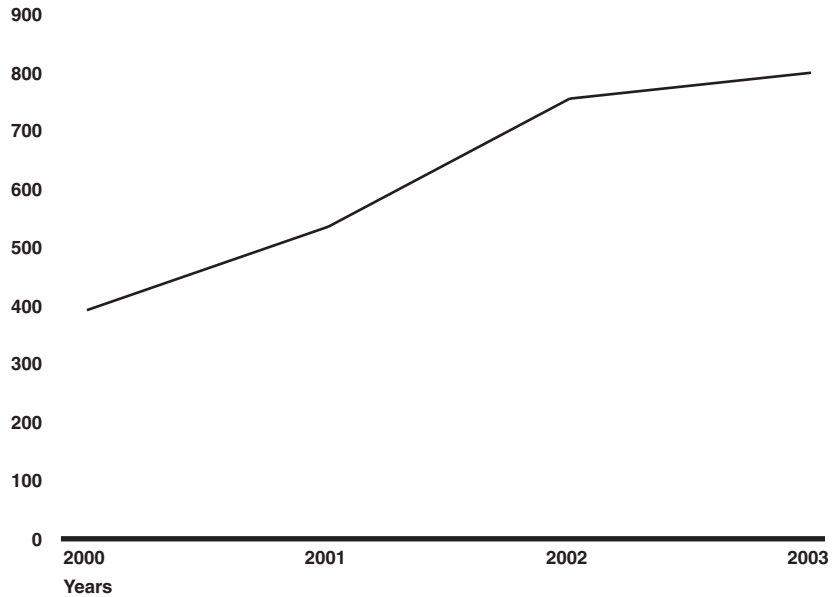
As discussed in prior OIG and GAO reports, reasons for untimely third-party billings were heavy caseloads and backlogs for cases to be coded. VA was unprepared to bill under reasonable charges initially in fiscal year 2000, particularly because of its lack of proficiency in developing medical documentation and coding to appropriately support a bill. As a result, VA reported that many of its medical centers developed billing backlogs.

In January 2003, we reported⁷ that after initially being unprepared in fiscal year 2000 to bill reasonable charges, VA began improving its implementation of the processes necessary to increase its third-party billings and collections. In fiscal year 2002, VA submitted over 8 million third-party insurance bills that constituted a 54 percent increase over the number in fiscal year 2001. VA officials attributed increased third-party billings to, among other reasons, reductions in billing backlogs and an increasing number of patients with billable insurance. We also reported that collections could be increased by addressing operational problems such as unpaid accounts receivable and missed billing opportunities due to insufficient identification of insured patients, inadequate documentation to support billings, coding problems, and billing backlogs.

To address these issues and further increase collections, VA has several initiatives under way and is continuing to develop additional ones. In September 2001, VA introduced its *Veterans Health Administration Revenue Cycle Improvement Plan*. This plan initially included 24 actions to improve revenue performance. After the establishment of the Chief Business Office (CBO) in May 2002, VA issued the *Revenue Action Plan* (Plan) that superceded the 2001 plan and includes 16 objectives. With the implementation of several actions in the Plan, VA has reported increases in the number of billings. For example, in fiscal year 2003, VA submitted 10 million bills, a 25 percent increase over the number of bills in fiscal year 2002 and a 160 percent increase over fiscal year 2000. VA also reported that its collections of third-party payments over the past few years continue to increase as shown in figure 2. For fiscal year 2003, VA reported that it collected third-party payments of \$804 million, a 6 percent increase over the \$760 million collected in 2002 and a 49 percent increase over the \$540 million collected in fiscal year 2001.

⁷ 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.: January 31, 2003).

Figure 2: Third-Party Collections (in millions)



Source: GAO analysis based on VA Performance and Accountability Report for fiscal year 2003.

Scope and Methodology

To gain an understanding of VHA's policies and procedures and the related internal controls for the billings and collections, to identify key control activities, and to assess the design effectiveness of those controls, we obtained and reviewed VA and VHA directives, handbooks, and other policy guidance, and previous reports issued by VA's OIG. We also conducted interviews and walkthroughs with VHA personnel and reviewed previous GAO reports. To assess whether key control activities for the two areas of operation were effectively implemented, we used a case study approach, reviewing transaction documentation at three VA medical centers. We selected medical centers with varying success in meeting established performance goals and other factors. Because we used a case study approach the results of our study cannot be projected beyond the transactions we reviewed.

To determine whether key internal controls for billings were effectively implemented, we discussed billing requirements and procedures with VHA headquarters and medical center personnel. Because billing records were not in a usable format and time constraints did not permit us to put them in

a usable format, we could not select a statistical sample. Instead, we made a non-statistical selection of 30 patients from each of the three medical center's inpatient and outpatient billing records to perform tests to assess compliance with policies and procedures and to determine the number of days to bill third-party insurance companies.

To determine whether key internal controls for collections were effectively implemented, we discussed requirements and procedures with VHA headquarters and medical center personnel. At each medical center we visited, we used the same 30 patients chosen for our billing tests to also assess compliance with accounts receivable policies and procedures, including VA Handbook 4800.14, *Medical Care Debts* (Handbook) and the *Accounts Receivable Third-Party Guidebook*.

We reviewed and used as guides, the *Standards for Internal Control in the Federal Government*⁸ and the *Internal Control Management and Evaluation Tool*.⁹ The Comptroller General issued these internal control standards to provide the overall framework for establishing and maintaining internal control. According to these standards, internal control, also referred to as management control, comprises the plans, methods and procedures used to meet the missions, goals, and objectives of an organization. Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud.

We performed our work at VA medical centers in Cincinnati, Ohio; Tampa, Florida; and Washington, D.C., and at the VHA's Chief Business Office in Washington, D.C. We conducted our review from March 2004 through June 2004 in accordance with U.S. generally accepted government auditing standards.

We requested comments on a draft of this report from the Secretary of Veterans Affairs or his designee. Written comments were received from the Secretary of Veterans Affairs and are reprinted in appendix I.

⁸ U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

⁹ U.S. General Accounting Office, *Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: August 2001).

Opportunities Exist for Improving Timeliness of Billings and Collection Activities

Although VA has decreased the number of days it takes to bill for patient services and has increased its collections from third-party insurance companies since 2000, problems remain. At the three medical centers we visited, we found continuing weaknesses in the billings and collections processes that impair VA's ability to maximize the amount of dollars paid by third-party insurance companies. For example, medical centers did not always bill insurance companies in a timely manner. According to medical center officials, timeliness of billing is affected by, among other things, (1) VA's ability to verify and update a patient's third-party insurance information, (2) whether physicians and other health care providers properly document the patient's treatment so a bill can be coded appropriately, (3) the extent of manual intervention to process the bill, and (4) workload. We believe that improvements could be made in each of these areas.

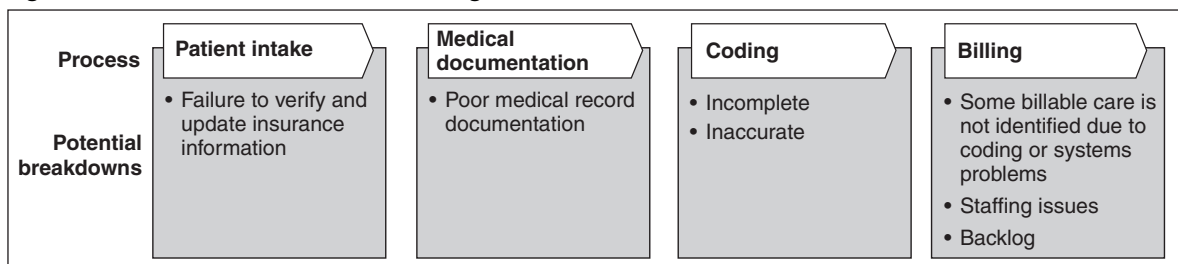
Further, the three medical centers we visited did not always pursue collections of accounts receivable in a timely manner or follow up on certain partially paid claims. Weaknesses in VA's collection activities hamper its ability to collect all monies due to the agency from third-party insurance companies to pay for veterans' growing demand for care.

VA's current Plan to implement and sustain effective collections operations is in process. However, the Plan has not been fully implemented. Therefore, it is too early to determine the extent to which it will address operational problems and increase collections.

Operational Enhancements Could Improve Timeliness of Billings

While VA reported that it has decreased the average number of days it takes to bill for patient services, we found that medical centers could further improve billing timeliness by continuing to address operational problems that slow down the process. These operational problems include, among other things, delays in verifying and updating patient insurance information, incomplete or inaccurate documentation of patient care by health care providers, manual intervention, and workload. VA's billing process cuts across four functional areas, as shown in figure 3. Each phase of the billing process is dependent on the completeness and accuracy of information collected in the prior phases. Breakdowns occurring during any part of the process can affect the timeliness of billings.

Figure 3: Four Functional Areas of Billing



Source: GAO analysis.

VA's policies and procedures do not specify the number of days for a bill to be issued once health care services are rendered. In fiscal year 2003, VA's Business Oversight Board established performance goals¹⁰ that were incorporated into the network and medical directors' performance contracts. The goal for sending a bill within a set number of days was reduced periodically during fiscal year 2004. During the time of our review, the performance goal for billing third party insurance companies was an average of 50 days from the date of patient discharge. As of the end of the first quarter of fiscal year 2004, the cumulative average days to bill third parties for Tampa, Washington, D.C. and Cincinnati were 73, 69, and 44 respectively.

At each of the three medical centers visited, we made a non-representative selection of 30 patients billed during the first quarter of fiscal year 2004. In evaluating the timeliness of billing, we used the then-in-effect performance standard of 50 days after patient discharge. We recognize that the cumulative billing times for the 90 cases selected do not represent the average days to bill, which VHA uses to measure each medical center's performance. However, cases billed more than 50 days after patient discharge are illustrative of problematic issues that can delay billings. For the 90 cases selected, the number of days to bill at the three medical centers we visited ranged from 5 to 332 days, with almost 30 percent billed after 50 days. A summary of our results is shown in table 1.

¹⁰ Billing performance goals (e.g. 50 days from the date of patient discharge) are computed as averages for designated time frames. Days to bill are calculated from the billing date back to the date when the patient was discharged.

Table 1: Third Party Billing Timeliness for Selected Transactions

Medical Center	Billed within 50 days	Billed > 50 days	Total bills tested
Cincinnati	23	7	30
Tampa	22	8	30
Washington, D.C.	19	11	30
Total	64	26	90

Source: GAO analysis.

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

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

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

example, in Cincinnati bills greater than \$100,000 or that have six or more medical procedure codes must be processed in this manner.

Another contributing factor may be the workload levels at the medical centers. During the second quarter of fiscal year 2004, Cincinnati submitted 45,883 bills and had a staff of 13 coders. Concurrently, Tampa submitted 192,407 bills and had 16 coders and Washington D.C. issued 64,474 bills and had 8 coders. VHA data indicated that Cincinnati's average billing time was under 50 days for the quarter and had the lowest bill to coder ratio. Conversely, Tampa and Washington, D.C. exceeded the 50-day performance goal and had a much higher bill to coder ratio. Assuming 60 workdays per quarter, we calculated the ratio of bills issued per day to the number of coders as shown in table 2.

Table 2: Ratio of Bills Issued to the Number of Coders Per Day January-March, 2004

Medical Center	Number of Bills/Per Day	Number of Coders	Ratio of Bills to Coders
Cincinnati	765	13	59:1
Washington, D.C.	1,075	8	134:1
Tampa	3,207	16	200:1

Source: GAO analysis.

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

VA's Controls over Collections Need Strengthening

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

Accounts Receivable Not
Pursued in a Timely Manner

VA's Handbook sets forth the requirements for collection of third-party accounts receivables.¹¹ Also, in 2003, the VHA's Chief Business Office issued the *Accounts Receivable Third-Party Guidebook* that lays out more detailed procedures.¹² Both documents require that once a claim has been sent to the insurance company, staff should follow up on unpaid reimbursable insurance cases as follows:

- The first telephone follow-up is to be initiated within 30 days after the initial bill is generated. All telephone follow-ups are to be documented to include, at a minimum, the name, position, title and telephone number of the person contacted, the date of contact, appropriate second follow-up date if payment is not received, and a brief summary of the conversation.
- A second telephone follow-up on unresolved outstanding receivables is to be made on an appropriate (but unspecified) date and documented.
- A third follow-up call is to be made within 14 days of the second contact and documented with a summary of the conversation and an appropriate, but not specified, follow-up date.
- If no payment has been received by the next follow-up date, the case may be referred by the MCCF Coordinator to regional counsel for further action.

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

Second follow-up phone calls were not made in a timely manner either. We considered 15 days after the initial follow-up of 30 days to be an appropriate time frame since the third follow-up is to be made within 14 days after the second follow-up and cases are to be referred to collection agencies after 60 days. Delays in making second follow-up calls increase

¹¹ VA Handbook 4800.14, *Medical Care Debts*, Department of Veterans Affairs, (Washington, D.C.: Dec. 8, 2003).

¹² *Accounts Receivable Third-Party Guidebook*, Department of Veterans Affairs, 2003.

the risk that payments will not be collected. Within our selected cases, four second follow-up calls were either made more than 15 days after the first follow-up call or not at all. These bills had not been paid within 120 days after the bill was sent to the insurance company.

Both the first and second follow-up calls require that staff document the contact's name, title, telephone number, and expected follow-up date in the official records. However, we found that staff did not consistently do so. For example, for the 14 cases where a follow-up call was made during the first 30 days after the initial billing, only seven specified a follow-up date. Entering a follow-up date would serve as a reminder to make the second follow-up call. Further, we found that an unclear collection policy may have contributed to VA's untimely second follow-up efforts. Specifically, VA's Handbook requires that second follow-up telephone calls on unresolved outstanding receivables be made on an "appropriate date," but that date is not specified (i.e., the number of days elapsed since the first contact). Specifying a follow-up date (i.e., 15 days after the first follow-up) or providing criteria for selecting an appropriate follow-up date would clarify this requirement and provide a benchmark on which compliance could be measured.

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

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

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

In non-Medicare cases, when the patient has primary and secondary insurance, VHA bills the primary insurance company and, depending on the amount collected, bills the secondary insurer for the residual amount. For Medicare patients who have secondary insurance (i.e., Medigap or Medicare Supplemental insurance), VA is generally entitled to receive payment only from the secondary insurance company. Thus far, VA has not been able to provide post-Medicare payment information (i.e., deductible

and co-insurance amounts) to other insurance companies because Medicare is generally not required to pay and thus does not pay VA. Lacking information on what Medicare would pay if required to do so, VA does not know what amount to bill the secondary insurance companies because it does not know the residual amount. In such cases, VA bills the secondary insurance company for the full amount associated with the care provided—the amount that would be reimbursable by Medicare as well as the amount not covered by Medicare.

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

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

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

VA Initiatives Are Under Way to Address Operational Problems

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

To assist in updating and verifying patients' insurance information, a problematic issue discussed earlier in our report, each site now has staff dedicated to (1) verify that insurance reported by the veteran is current, (2) determine insurance coverage if the patient does not declare any, (3) acquire pre-certifications of patient admissions, and (4) obtain authorization of procedures from the patient's insurance company. Additionally, medical centers have taken actions to update demographic information on file, including insurance. These efforts help to reduce insurance denials, produce more accurate bills, and ensure that VA receives reimbursement for services provided.

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

To reduce billing backlogs, VHA entered into an agreement with four vendors to code and assist with backlogs. The Washington, D.C. medical center hired a contractor to handle a backlog of 15,000 encounters.¹³ The contractor has certified staff for coding and billing and must meet 12

¹³An encounter is defined as a single medical treatment.

performance measures. The revenue officer told us that the backlog was eliminated in May 2004. In addition, in December 2003, VHA was given authority by the Office of Personnel Management to directly hire credentialed coders at industry-compatible salaries.

In fiscal year 2003, VHA's Chief Business Officer implemented industry-based performance metrics and reporting capabilities to identify and compare overall VA revenue program performance. Metrics were introduced to measure collections, days to bill, gross days revenue outstanding, and accounts receivable over 90 days. For both network and medical center directors, the metrics and associated performance targets were incorporated into annual performance contracts effective fiscal year 2003. VHA officials attribute much of the decrease in days to bill and increased billings and collections to these performance measures. For example, VA reported that nationally the average days to bill insurance companies for the first half of fiscal year 2004 was about 74 days, which is an improvement from their fiscal year 2000 average days to bill of 117 days. However, VHA's average days to bill for that period exceeded the performance goals of 50 days and 47 days for the first and second quarters of fiscal year 2004, respectively. The industry standard is 10 days.¹⁴

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

¹⁴As we noted in our 2003 report, VA's performance does not compare favorably to some industry benchmarks, such as the number of days required to bill. However comparisons between VA and the private sector should take into account how VA's processes differ from those in the private sector. For instance, VA has the additional step of determining whether the care is service-connected, and VA bills for both facility and physician charges. By comparison, private sector hospitals may only bill for facility charges.

Another effort under way, the electronic Medicare Remittance Advice project, helps to address obtaining allowable payments from secondary insurance companies, rather than accepting partial payments that are significantly lower than billed amounts as full payment. This project involves the electronic submission of claims to a fiscal intermediary¹⁵ to receive remittance advice on how Medicare would have paid the claim if it were legally bound to pay VA for care. The remittance advice, which will be attached to VA health care claims, will enable secondary insurance companies to determine the correct amount to reimburse VA. Further, VA believes it will be able to more accurately reflect the amount of its outstanding receivables and be in a strengthened position to follow up on partial payments, which it deems incorrect. The completion date for this project was November 2003 but has been delayed due to software issues. VA officials told us they plan to roll out the new system beginning in August 2004.

Although the Plan provides another step forward in potentially improving operations and increasing collections, it is still in progress and many of the actions are not scheduled for implementation until at least fiscal year 2005. Therefore, it is too early to determine whether the Plan will successfully address operational problems and increase collections when fully implemented.

Conclusions

The growing demands for veterans' health care increase VA's responsibility to supplement, as much as possible, its medical care appropriations with collections from insurance companies for treatment of non-service-connected conditions. VA is making progress in developing and implementing procedures to identify patients who can be billed for services, to bill for services correctly and in a timely manner, and to pursue collections. VA's Plan to further improve billing and collection operations, however, is still a work in progress and could benefit from the performance of a workload analysis. In the interim, strengthening internal controls such as clarifying billing and claims follow-up procedures and consistently implementing policies and procedures could help reduce billing times and increase collections. Even assuming that its Plan works as contemplated, these additional controls are needed to maximize VA revenues to enhance its medical care budget.

¹⁵A private company that contracts with Medicare to pay Medicare Part A and some Part B bills.

Recommendations

We are making five recommendations to facilitate more timely billings and improve collection operations. The Secretary of Veterans Affairs should direct the Under Secretary for Health to:

- Perform a workload analysis of the medical centers' coding and billing staff, and
- Based on the workload analysis, consider making the necessary resource adjustments.
- Reinforce to accounts receivable staff that they should perform the first follow-up on unpaid claims within 30 days of the billing date, as directed by VA Handbook 4800.14, *Medical Care Debts*, and establish procedures for monitoring compliance.
- Reinforce the requirement for accounts receivable staff to enter the insurance company contact's name, title and phone number and the follow-up date when making follow-up phone calls.
- Augment VA Handbook 4800.14, *Medical Care Debts*, by either specifying a date or providing instructions for determining an appropriate date for conducting second follow-up calls to insurance companies.

Agency Comments and Our Evaluation

VA provided written comments on a draft of this report. In its response, VA agreed with our conclusions and recommendations and reported that it is developing an action plan to implement them. Additionally, VA's response stated that VHA is pursuing a number of strategies to improve overall performance toward achieving industry benchmarks. VA believes that the development of the Patient Financial Services System will address current billing system limitations and manual intervention and that the Medicare Remittance Advice project will assist VHA in pursuing partially paid claims.

Also, in its response letter, VA included some technical comments that we have addressed in finalizing our report where appropriate. VA's written comments are presented in appendix I.

As arranged with your office, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Veterans Affairs, the Under Secretary for Health, interested congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>. Should you or your staff have any questions on matters discussed in this report, please contact me at (202) 512-6906 or williamsm1@gao.gov; or Alana Stanfield, Assistant Director, at (202) 512-3197 or stanfielda@gao.gov. Major contributors to this report are acknowledged in appendix II.

Sincerely yours,

A handwritten signature in cursive script that reads "McCoy Williams".

McCoy Williams
Director, Financial Management and Assurance

Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

July 14, 2004

Mr. McCoy Williams
Director
Financial Management and Assurance
U. S. General Accounting Office
441 G Street, N.W.
Washington, DC 20548

Dear Mr. Williams:

The Department of Veterans Affairs (VA) has reviewed the General Accounting Office's (GAO) draft report, ***VA MEDICAL CENTERS: Further Operational Improvements Could Enhance Third-Party Collections*** (GAO-04-739), and agrees with GAO's conclusions. The Department concurs with GAO's recommendations. Technical comments are being sent to GAO for clarification under separate cover.

GAO recognizes the distinctions between VA and private sector billing processes. For example, unlike the private sector, VA is required to determine whether or not an episode of care is service connected, which is not third-party billable. Currently, VA accepts third-party partial payments that may be significantly lower than full payment while the private sector does not and while VA is required to bill for both physician and facility charges, the private sector only bills for facility charges. These distinctions make it difficult for meaningful comparisons of VA with the private sector to be made on industry benchmarks.

The Veterans Health Administration (VHA) is pursuing a number of strategies to improve its overall performance as VHA focuses on achieving industry benchmarks. VA believes the system limitations related to billed amounts and procedure codes cited in GAO's report will be resolved as VA continues to develop the Patient Financial Services System (PFSS) and implement the Health Insurance Portability and Accountability Act (HIPPA). The PFSS will streamline the billing process and reduce manual interventions. The Medicare Remittance Advice (MRA) project will assist VHA in following-up on partially paid claims. VHA is testing the MRA and expects to begin national rollout in August 2004 with a projected completion date of October/November 2004.

Appendix I
Comments from the Department of Veterans
Affairs

Page 2.

Mr. McCoy Williams

Due to the limited amount of time to comment on GAO's draft report, VHA is still developing an action plan to implement GAO's recommendations. VA will provide the action plan in its comments to GAO's final report. Thank you for the opportunity to review your draft report.

Sincerely yours,



Anthony J. Principi

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Alana Stanfield, (202) 512-3197

Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Teresa Broadie-Gardner, Lisa Crye, Jeffrey Isaacs, Sharon Loftin, Donell Ries, and Patricia Summers.

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