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VA HEALTH CARE

VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) continuing efforts to increase its collections from veterans' private health insurers. VA has the authority to bill and retain all collections from these third-party insurers for any health care it provides to veterans for non-service-connected conditions. Collections from third-party insurers are VA's largest source of revenue and are used to supplement its medical care appropriations.

Over the past several years, concerns have been raised about VA's ability to optimize its third-party revenues. For example, in 1997 we reported that VA was billing for medical care that it could not expect to collect.[1] In 1998, a national VA review found process inefficiencies, significant errors resulting in rework, and ineffective use of available automation.[2] In the same year, VA's Office of the Inspector General indicated that VA was not billing all appropriate episodes of care and not aggressively pursuing unpaid bills.[3] And in 1999, we testified on our concerns about declining VA collections and its uneven management improvements across facilities.[4] While these and other assessments recognize a number of largely uncontrollable factors that limit VA's potential revenue—such as the declining number of veterans and smaller bills associated with VA's shift from inpatient to outpatient care—they all found that VA's process for collecting payments from third-party payers has limited the amount of revenue it has generated.

In 1999, VA submitted a business plan to the Congress that called for an evaluation of two major alternatives for improving revenue operations and collections. Both alternatives called for each network to consolidate portions of the revenue operations, but one alternative called for using in-

[1] *VA Medical Care: Increasing Recoveries From Private Health Insurers Will Prove Difficult* (GAO/HEHS-98-4, Oct. 17, 1997).

[2] *VA MCCR National Study: Cost Assessment and Best Practices*, Coopers and Lybrand (Apr. 21, 1998).

[3] *Audit of the Medical Care Cost Recovery Program*, VA Office of Inspector General (July 10, 1998).

[4] *VA Health Care: Collections Fall Short of Expectations* (GAO/T-HEHS-99-196, Sept. 23, 1999).

house staff while the other would have used contractor staff.[5] My testimony today will focus on the status of VA's collections this past year and VA's progress in pursuing its business plan. To assess VA's efforts, we visited revenue operations at four facilities[6] and one network;[7] surveyed all facilities and networks and interviewed headquarters officials; obtained and analyzed private sector benchmarks;[8] and reviewed relevant VA studies and plans, including its September 2001 Revenue Cycle Improvement Plan.

In summary, this fiscal year, for the first time since fiscal year 1995, VA has reversed the general decline in its third-party collections. However, the fiscal year 2001 increase appears to be largely the result of VA's implementation of a new system, known as the reasonable charges billing system, which allowed VA to move from a flat-rate billing system to one that itemizes charges for the care it provides to veterans. However, long-standing problems in VA's revenue operations appear to persist, and when compared to private sector standards, VA's collections performance is poor. For example, VA takes 14 times longer to bill, on average, than a benchmark for private sector hospitals. Moreover, VA's various attempts to try consolidation using either in-house or contractor staff have provided little basis for selecting the best alternative to address VA's collections problems. For example, VA initiated a pilot to test the relative cost-effectiveness of contracting out or using in-house staff, but as a result of changes in the pilot's design for contracting, this test is unlikely to yield data needed to compare the two alternatives and determine which option is best. In addition, VA's recent 2001 Revenue Cycle Improvement Plan does not call for a comprehensive comparison of alternatives nor does it focus on net revenues—collections minus operations costs. To collect the

[5]VA could competitively determine whether it would be more cost-effective to retain the work in-house or contract it out through the use of Office of Management and Budget's (OMB) Circular A-76 process. In the A-76 process, the government identifies the work to be performed—described in the performance work statement—and prepares an in-house cost estimate, based on its most efficient organization, to compare with the winning offer from the private sector.

[6]For this report, facilities will only refer to VA medical centers that have revenue operations.

[7]The management of VA's hospitals and other health care facilities is decentralized to 22 regional networks, known as Veterans Integrated Service Networks.

[8]Based on a national quarterly survey of private sector hospitals, the *Hospital Accounts Receivable Analysis* report provides averages for various billing and collections activities that can serve as benchmarks of performance.

most funds for veterans' medical care at the lowest cost, VA needs to develop a business plan and detailed implementation approach that will provide useful data for choosing the best alternative for optimizing net revenues from third-party payments.

Background

When veterans receive care from VA for non-service-connected conditions, the law allows VA to bill the veterans' private health insurers and retain these third-party collections to supplement its appropriations for health care. Third-party insurers include individual and group insurance plans, Medicare supplemental insurance plans,[9] and self-insured employer plans.

In January 1997, VA proposed a 5-year plan to operate with a flat annual appropriation of $17 billion per year through fiscal year 2002. As part of this plan, VA anticipated that by the end of fiscal year 2002, it would obtain 10 percent of its funding from third-party collections and other alternative revenue streams, such as veteran copayments, Medicare payments, and proceeds from sharing agreements (where VA sells services to the Department of Defense, private hospitals, and other providers). In fiscal year 2000, VA acknowledged that it would not meet its 10-percent goal, in part because the Congress did not authorize Medicare payments to VA for health care provided to Medicare enrollees. For fiscal year 2002, VA estimates that revenue from alternative sources would be about 4 percent of its medical care funding, or $896 million.

VA's third-party revenue operations consists of five sequential processes. (See table 1.)

[9]Medicare supplemental insurance is private insurance to cover expenses not covered by Medicare, such as deductibles, copayments, coinsurance, and prescription drugs.

Table 1: VA's Revenue Operations Processes

Revenue operations process	Description
Patient intake	Includes registration of patient information, verification of insurance, and other medical administrative services.
Medical documentation	Involves properly documenting the health care provided to patients by physicians and other health care providers, and determining whether or not the care is for a service-connected condition.
Coding	Involves assigning correct codes for diagnoses and medical procedures based on the documentation.
Billing	Involves creating and sending bills to insurance carriers based on insurance and coding information.
Accounts receivable	Includes payment processing and follow-up with insurers on outstanding or denied bills.

With the exception of six networks that have consolidated some of these processes, revenue operations management is currently decentralized and the processes are performed at each medical center where health care is provided to veterans.

In the 1990s, VA sponsored two studies comparing the cost-effectiveness of contracting out most revenue operations. The results of these studies were not fully conclusive and were contradictory. The first study, conducted by Birch and Davis and reported on in 1995, concluded that VA's costs would be slightly less if operations were maintained in-house instead of using a contractor.[10] In contrast, the second study, conducted by Coopers and Lybrand and reported in 1998, found that, based on three contractors' estimates, contracting out would be less expensive.[11]

Collections Have Increased in the Past Year, but Underlying Problems Continue

If VA's current pattern of third-party collections continues into the last months of fiscal year 2001, VA will significantly increase its third-party collections for the first time since fiscal year 1995. However, the increased collections are likely the result of VA's generally charging more for each episode of care—which occurred with the implementation of billing reasonable charges for individual services. Not only do long-standing

[10] *Medical Care Cost Recovery Cost of Collections Study*, Birch and Davis Associates, Inc. (Oct. 17, 1995).

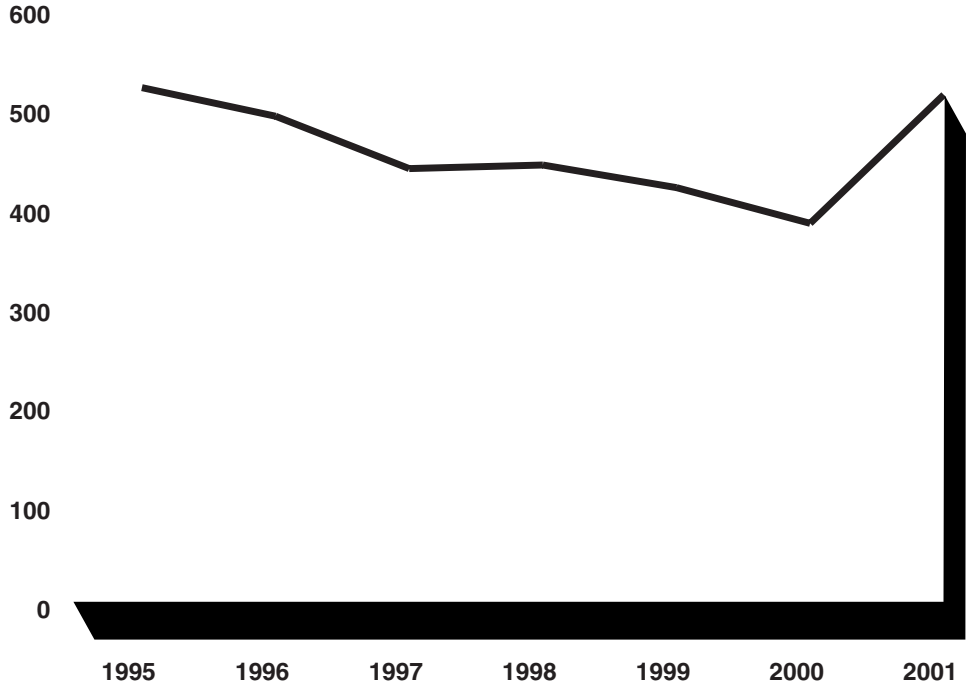
[11] *VA MCCF National Study: Cost Assessment and Best Practices*, Coopers and Lybrand.

problems in revenue operations appear to persist—which have been heightened with the implementation of reasonable charges—when compared to private sector benchmarks, VA's collections performance is poor. Moreover, the revenue program's information systems and lack of departmentwide standardization create overarching weaknesses for managing and improving revenue operations and collections nationally.

VA Collections Have Increased Since the Implementation of Reasonable Charges

Based on monthly collections for the first 10 months of fiscal year 2001, we project that VA will receive over $500 million from third-party collections this year. This amount is a significant increase over last fiscal year—and the largest amount collected since fiscal year 1995, when $523 million was collected. (See fig. 1.)

Figure 1: Third-Party Collections Since Fiscal Year 1995



Note: 2001 projection calculated by GAO based on VA Revenue Office data.

VA expected its collections to increase as a result of its reasonable charges billing system, which was implemented in September 1999. Under this system, VA began using itemized billing for the services provided—rather than charging flat fees, as it had done prior to 1999. According to a VA

analysis, in the first 8 months of fiscal year 2001, VA treated about the same number of patients but collected 34 percent more dollars than the comparable period in fiscal year 1999 before reasonable charges were implemented.[12]

Long-Standing Problems in VA's Revenue Operations Limit VA's Collections Performance

Although the implementation of the reasonable charges billing system has increased VA's collections over the past year, VA faces a number of long-standing problems in managing its revenue operations. In addition, VA's collections performance falls short of private sector benchmarks.

Inadequate intake procedures, lack of sufficient physician documentation, shortage of qualified coders, and insufficient automation diminish VA's collections.

- Patient intake: To determine which veterans have insurance, VA must rely on voluntary disclosure of insurance by veterans.[13] Nationally, VA bills insurers for only 16 percent of patients treated but reports that substantial numbers of veterans have probably not disclosed their insurance.
- Medical documentation: About 74 percent of surveyed facilities reported that weaknesses in physicians' documentation of care for billing purposes limits collections. One official was concerned that his facility could not meet its timeliness goal unless clinical staff provided more timely documentation for billing. He also noted that not all billable care could be charged to insurers because of incomplete or insufficient documentation. A VA contractor this year estimated that VA could collect $459 million more nationally if physicians' oversight of resident physicians was properly documented. However, the contractor also found that some physicians were concerned that spending more time on documenting care for billing purposes would take away from the time spent with patients.
- Coding: VA has acknowledged its difficulty maintaining sufficient staff who can correctly code medical procedures and services for billing. A 2000 study also found these problems and attributed them to competition from other employers for coders, low VA entry-level wages, and VA's frequent problems with retaining and promoting qualified and proficient

[12]In fiscal year 2000, as facilities adjusted to the new requirements to bill under reasonable charges, national collections initially decreased.

[13]According to a VA official, no other reliable source exists. In addition, unlike beneficiaries with private insurance, veterans are not responsible for paying the remainder of their VA bills, and thus do not have the same financial incentive to disclose insurance to VA.

staff.[14] At three sites we visited, for example, revenue officials noted that they had difficulties hiring experienced coders at VA salaries.

- Billing: A VA-sponsored 2001 study of the possible uses of commercial software found limitations in VA's current billing software that led to manual processes. As a result, there is an increased probability of errors, slower production, and lower collections. A contractor who provided services to both VA and private sector hospitals also told us that VA's process for creating bills and identifying errors is less automated than the private sector.
- Accounts receivable: The majority of VA's accounts receivables exceed 90 days and VA is concerned that insufficient follow-up is given to collections. According to a contractor that services both VA and private sector hospitals, VA staff at one facility were not following standard business practices of contacting insurers to resolve problems with bills but instead were just sending additional copies of bills. At another site we visited, two accounts-receivable staff were having difficulties reducing a backlog of about 3,000 to 4,000 unpaid claims because each day they were only able to make a total of 60 follow-up calls to insurers.

Private sector hospitals appear to manage these processes more efficiently.

- VA's average lag times from the date of discharge or care to the date of billing are 74 days for inpatient care and 143 days for outpatient care. In comparison, private sector benchmarks indicate that 5 and 6 days, respectively, are more typical in the private sector hospitals.
- The majority of VA's accounts receivables are over 90 days old from date of discharge or care, compared to a private sector benchmark of 29 percent of uncollected dollars exceeding 90 days.
- A VA-sponsored 1998 study estimated that VA's full cost to collect one dollar of third-party revenue was 7 cents for inpatient bills and 48 cents for outpatient bills, compared to a benchmark of slightly over 2 cents in the private sector.[15]

[14] Gary Nugent et al., "Third Party Billing in the VHA: A Look at Cost and Policy," *Federal Practitioner* (Nov. 2000).

[15] The large difference between VA's inpatient and outpatient costs to collect resulted, in part, because VA had to generate approximately 20 outpatient bills to produce recoveries equivalent to 1 inpatient bill.

Comparisons between VA and private sector hospitals, however, are not perfect because their operations and payer mix differ. For example, VA bills both for facility and provider charges, whereas the two private sector hospitals we visited only billed for facility charges; medical groups bill separately for physician fees. In addition, VA can only collect on the Medicare supplemental portion of the payment, whereas the private hospital can collect both Medicare and supplemental payments. VA reports that about 70 percent of its bills are sent to Medicare supplemental insurers, and for these, it can only expect to collect abut 20 percent of the billed amount. Consequently, VA would have a higher cost-to-collect ratio even if it were as efficient as its private sector counterparts. Although these differences make comparisons with private sector average performance imperfect, the disparity of performance suggests that the average VA operation is not very efficient.

Implementing Reasonable Charges Created New Process Challenges and Exacerbated Existing Ones

By replacing a billing system that used a limited number of flat fees for broadly defined types of care with one based more on individual charges for the services actually given, the new reasonable charges system made accurate coding and documentation more critical for billing and increased workload because multiple claims could result from a single episode of care.

Before implementing its reasonable charges billing system, VA used nine inpatient rates, based on a particular hospital unit, such as a surgical bed section, and one outpatient visit rate. Under the reasonable charges billing system, VA assigns hundreds of diagnoses codes and thousands of procedure codes based on the documentation of the services provided to veterans. Therefore, before reasonable charges, an outpatient surgery, such as one to repair a hernia, would result in one all-inclusive charge. Under reasonable charges, VA must now create separate bills for physician charges and for outpatient facility charges for the same outpatient surgery. Although estimates varied at the sites we visited, one official estimated that using reasonable charges increased the number of bills by about 5 times.

Officials at all sites we visited reported acquiring more staff—both in-house and through contracts—to process bills under reasonable charges. For example, since reasonable charges was implemented, one site's total number of coders and billers more than doubled, from 7 to 19. Based on the 133 facilities reporting to our survey, increases of VA staff continued into this fiscal year. Full-time equivalent positions for revenue operations

have increased from 2,284 in fiscal year 2000 to 2,411 by the middle of fiscal year 2001.

Decentralized Responsibilities Also Present Challenges

VA is also challenged to successfully direct and manage a highly decentralized program with practices and performances that vary widely by facility. VA has noted that although its national policies address key components of revenue operations, they are not followed in a standard and consistent manner. For example, VA has encouraged physicians to enter their notes electronically; however, physicians at one location we visited were dictating their notes for transcription, which were then transferred to the electronic system. At another site, an official told us that while other facilities were able to create an electronic interface with an intermediary to transmit bills to insurance companies, his facility had not. Therefore, bills were keyed in and printed, then re-keyed in by data entry staff to allow electronic transmission to the intermediary.

Collections performance also varies widely from facility to facility. For example, one facility takes an average of 16 days to send an inpatient bill, while another averages 342 days. Facilities' performance in cost to collect were similarly diverse. According to data reported to us by facilities for the first half of fiscal year 2001, VA's average personnel cost to collect a dollar was 24 cents across both inpatient and outpatient bills,[16] with facilities in the top 25 percent of performance reporting personnel costs to collect a dollar ranging from 5 to 15 cents and facilities in the bottom 25 percent of performance reporting personnel costs to collect a dollar ranging from 31 to 64 cents.

In addition, the data accumulated from the various facility systems are not adequate to nationally manage performance. VA notes that the lack of software and data standardization across facilities impairs its ability to consistently measure performance and set performance goals. Moreover, because VA's accounting system does not break out third-party collections or operations costs, net revenues (that is, gross revenue collections minus operations costs) cannot be monitored at a national level. According to an official at VA's national headquarters, data on facility performance are also unreliable because they are not verified. For example, some facilities

[16]VA's full cost to collect would be even higher if nonpersonnel and other overhead costs (such as supplies, equipment, and senior management) were added. For example, according to Birch and Davis' 1995 study of VA's costs, travel, postage, and other indirect costs accounted for about 10 percent of total costs.

reported high and unreasonable numbers—such as thousands of days to bill—which the facilities could not explain. It is not clear then, whether variations in facility performance reflect better or worse performance or unreliable data.

Efforts to Improve Collections Provide Little Basis to Select the Best Alternative for Optimizing Net Revenue

The various efforts VA has undertaken to improve its revenue operations fall short of providing a basis to select among the two major alternatives—contracting out or using VA staff. VA's 1999 business plan to the Congress indicates that contracting could improve operations by incorporating the private sector's best billing and collection practices and efficient automation. While some networks and facilities have contracted out portions of their revenue operations, these efforts do not provide VA the data needed to compare contracting with using in-house staff. Moreover, VA's efforts have not sufficiently considered the importance of net revenues—collections minus operations costs—a key criterion for choosing among alternatives. VA also initiated a pilot to test the relative cost-effectiveness of contracting and using in house staff, but as a result of changes in the pilot's design, it is unlikely to yield data that allow comparisons of each alternative's net revenues.

At the Secretary's initiative, VA developed its 2001 Revenue Cycle Improvement Plan. Our preliminary assessment of the plan is that it also will not provide VA a sufficient rationale to choose wisely among alternatives for optimizing net revenues.

Some Networks and Facilities Are Using Contracting

VA's 1999 business plan indicates that once networks consolidated their revenue operations, contracting might improve operations because competitive bids for the contract should reflect the cost of an efficient operation. The business plan also indicates that contract incentives and the desire to keep the contract could encourage contractors to keep costs down and profitably collect every billed dollar. The 1999 business plan further suggested consolidating some network operations with a high-performing VA unit within the network as a comparison to contracting. Both approaches could increase standardization of processes and introduce best practices.

Some networks have consolidated some revenue operations. Networks and facilities have also used contracting, but these contracting efforts have primarily been small-scale and aimed at addressing immediate problems. Few facilities have contracted out an entire process of revenue operations. (See table 2.)

Table 2: Consolidation and Contracting of Revenue Operations Processes

Process of revenue operations	Network consolidation (22 networks)	Network contracts (22 networks)		Facility contracts (133 reporting facilities)[a]	
		All of process	Some of process	All of process	Some of process
Patient intake[b]	27% (6)	0%	5% (1)	0%	17% (23)
Medical documentation[c]	NA	NA	NA	NA	NA
Coding	0%	14% (3)[d]	27% (6)	4% (5)[d]	35% (47)
Billing	14% (3)	0%	32% (7)	1% (1)[e]	42% (56)
Accounts receivable	18% (4)	0%	41% (9)	0%	69% (92)

[a]Six facilities, including five in one network with consolidated operations, did not report to us.

[b]Counted as "all of process" if contractors did all of the intake tasks of pre-registration, insurance identification, and insurance verification.

[c]Medical documentation must be done by VA clinical staff at facilities.

[d]Counted as "all of process" if contractor coded either all inpatient or all outpatient cases.

[e]Counted as "all of process" if contractor billed either all inpatient or all outpatient cases.

VA facilities and networks reported to us that most of their contracts are viewed as temporary to meet immediate needs, such as supplementing their staffs to reduce backlogs of claims. Revenue operations managers also voiced a number of concerns that indicated that they would be unlikely to pursue extensive contracting. Our survey showed that less than 1 percent of either network or facility revenue-operations managers reported that contracting out the majority of revenue operations would be the most effective alternative. In addition, they noted various implementation barriers that would have to be resolved. For example, contractors would need to be trained about VA's rules and regulations, an interface between VA's and the contractor's computer systems would need to be developed, and union issues that would arise around the loss of VA jobs would need to be addressed.

A recent VA-sponsored survey of eight health care revenue collection firms and a VA-hosted vendor conference indicated that contractors have an interest in performing most revenue processes—from intake through accounts receivable—and they had anticipated some of the barriers facilities and networks identified. For example, contractors identified the need to establish an interface with VA's data systems. Without such an interface, the contractor might only be able to provide contract workers to use VA's data systems rather than to bring the full capacity of the

contractor's own data systems to improve operations. The contractors also believed that if the contractor were only engaged in the latter parts of revenue operations—billing and accounts receivable—the effect on increasing collections would be limited because generating additional revenue is critically affected by front-end activities such as insurance identification, documentation, and coding.

While there were similar concerns about consolidation, it appears to have more acceptance among VA revenue managers than extensive contracting. In our survey, 36 percent of network respondents and 11 percent of facility respondents indicated that network-level consolidation would be the most effective alternative for managing third-party collections. For consolidation, respondents cited union and morale issues regarding the movement or loss of jobs and sharing information between facilities as implementation challenges.

Pilot to Test Contracting Out Will Not Provide Needed Data

VA has initiated a pilot that was intended to test the contracting alternative and to use the data from this test to evaluate whether consolidation using in-house staff or contractors would improve net revenues and other key outcomes. However, it fails to meet this key objective. While the pilot may provide some information on whether consolidation of some processes at a network-level could improve net revenues and other outcomes, it will not provide useful data for choosing between the in-house and contract options because a pilot site for gathering similar information on contracting was not established.

According to a VA headquarters official, the networks were reluctant to volunteer for the pilot because of concerns that if the contract did not work out, they would have lost the expertise of the in-house employees who had worked on revenue operations. Two networks have agreed to pilot the consolidation using in-house staff alternative, and a third network will pilot consolidation with limited contracting out. A fourth network has contracted out one task of patient intake—insurance verification.

This fourth network had also planned to use another contract for coding, billing, and accounts receivable, although retaining VA employees to process backlogs in these same areas. This pilot could have yielded useful data for comparing the two alternatives. However, after a number of delays and plans to limit the contract to 3 months at a single facility, VA has not found an acceptable contractor and even this abbreviated test of contracting out is unlikely to occur.

Current Improvement Plan Focuses on Enhancing In-House Operations, Not Net Revenues

VA's Revenue Cycle Improvement Plan, finalized in September 2001, does not position the Department to choose between the two major alternatives for optimizing its third-party collections because the plan does not call for a comprehensive comparison of these two options nor does it focus on net revenues—collections minus operations costs. Instead, the plan seems to present a decision to improve in-house operations in the short term, and later consider the alternatives.

In the short term, the plan calls for 24 actions to address problems throughout VA's revenue operations—such as training coders and tracking documentation—over a 2-year period. However, the plan does not establish a way to gather data on the alternatives because nearly all of the efforts to improve revenue processes are to be undertaken at the facility level with VA staff. The only planned consolidation would be establishing, for a 3-month period this year, a single in-house group at headquarters or using a contractor to handle accounts receivable older than 90 days.

VA also plans to implement in the near term three national contracts for electronic services. However, these contracts will primarily supplement facilities' billing and collection efforts rather than replace VA operations. One nationwide contract will establish an electronic data interchange for the electronic submission of bills to insurers to help ensure faster turnaround of payments and reduce errors due to automated edits during the transmission process. A second contract—a Medicare Remittance Advice contract—will provide an explanation of what Medicare would have paid for VA's medical services, thereby clarifying the remaining amount for the supplemental insurer to pay. The third contract—a lockbox contract—will replace the current manual, paper-based process of receiving and posting payments with an automated process.

The plan's vision for considering both consolidating and contracting is for the longer term. For example, the plan calls for considering the viability of contracting out billing and accounts receivable as well as the supporting software system after the 24 actions have been taken.

Moreover, although the September 2001 plan calls for cost-benefit analyses for specific proposed actions with major investments, the plan is unclear as to how VA will decide which, if any, investments it will make prior to deciding whether it will choose the contracting alternative. For example, the plan indicates the need to acquire a new computerized billing and collections system—which according to a 2001 VA-sponsored study of commercial software could be a major investment, likely from $75 million to $125 million. However, in a discussion of future contracting, the plan

states that VA could avoid large capital expenditures and gain a faster deployment if it used a contractor that provided the billing and accounts receivable software.

Finally, the plan does not consider net revenue. Without such a consideration, VA will not be able to measure the extent to which funds are actually generated to supplement appropriated funds for veterans' health care.

Concluding Observations

VA's efforts to date have not provided it the data needed to compare program expenditures and collections and to choose among the major alternatives of contracting or using in-house staff for its revenue operations. Nor does VA establish net revenue as a criterion in its recent improvement plan to address weaknesses in facility managed operations and later consider the in-house staffing and contractor alternatives. Without a credible business case for increasing expenditures that result in more net revenue, VA's budget officials will be at odds regarding how to spend sizeable portions of VA's resources—on revenue operations or on medical care.

While VA has used competitive sourcing to a limited extent, it could realize additional savings by competing, through the use of OMB's Circular A-76, the costs of government providing these services in-house versus the costs of buying them from the private-sector. Our work at the Department of Defense shows that, by competitive sourcing under OMB Circular A- 76, costs decline through increased efficiencies whether the government or the private sector wins the competition to provide services.[17] This work indicates that savings are probable for VA, but we cannot estimate potential savings from competitive sourcing because of uncertainty regarding the availability of interested contractors, the price of contractor services, and the extent to which VA is able to decrease its operating costs in a competitive process.[18]

[17]See *DOD Competitive Sourcing: Some Progress but Continuing Challenges Remain in Meeting Program Goals* (GAO/ NSIAD-00-106, Aug. 8, 2000) for a discussion of the benefits of competing various efficiency options using the OMB Circular A-76 process.

[18]See *DOD Competitive Sourcing: Savings Are Occurring, but Actions Are Needed to Improve Accuracy of Savings Estimates* (GAO/ NSIAD- 00-107, Aug. 8, 2000) for a discussion of calculating savings under the OMB Circular A-76 process.

A recent House Committee on Appropriations' report accompanying the fiscal year 2002 appropriations bill includes funding for VA to create a demonstration of a contractor-installed and operated financial system for revenue operations. Such a demonstration might provide an opportunity to test the contracting alternative relative to in-house alternatives. The contractor's financial system, which would supplement VA's system, would be a prototype under the demonstration. It is intended to provide functions to overcome current deficiencies in such areas as verifying insurance, accumulating all charges for care, ensuring proper coding, producing bills, and managing the collections process.

VA's current pilot has consolidated operations at some networks, and its recent improvement plan is designed to improve in-house operations over about a 2-year period. If VA then gathered appropriate information on net revenues and other key outcomes for these alternatives, it would be better positioned to make a fact-based decision among them in a manner envisioned by OMB A-76.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

Contact and Acknowledgments

For further information, please contact Stephen P. Backhus at (202) 512-7101. Ron Guthrie, Terry Hanford, Jean Harker, Mike Gorin, and Karen Sloan also made key contributions to this testimony.

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