

**STATEMENT OF
THOMAS L. GARTHWAITE, M.D.
UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES**

SEPTEMBER 20, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to have the opportunity to discuss the progress, challenges, and future direction of the Department of Veterans Affairs (VA) Veterans Health Administration's (VHA) revenue program. Accompanying me are Mr. Jimmy Norris, VHA's Chief Financial Officer, and Mr. Don Pratt, Acting Associate Chief Financial Officer for Revenue.

To provide some good news at the outset of my testimony, collection statistics through August 2001 of this fiscal year show a collections total of over \$708 million, which is an increase of nearly 40 percent over last fiscal year collections for the same time frame. We estimate that total fiscal year collections will be over \$750 million, which will be the largest amount of collections experienced in the history of the revenue program. Even with this large gain in collections, there is potential for increased collections.

At the Secretary's request, VHA prepared a detailed report on how to improve collections. A copy of that report has been provided to the committee and a brief description of the plan is attached to my statement. We are making a concerted effort to develop clear management responsibility for all aspects of the program and are striving to hold all employees accountable. We are stressing improvement in data capture, insurance identification and records documentation to enhance the billing process. We are also

stressing the need to build a strategy for resolving weaknesses in the current billing and collection process. The strategy may include outsourcing some or all billing and collection functions. This topic is discussed later in this testimony.

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.

Additional laws were enacted which extended the sunset provisions for billing health insurance carriers of service-connected veterans for their NSC conditions and copayment billing authority. Legislation is currently pending to further extend these authorities.

Public Law 105-33, enacted August 5, 1997, established our current Medical Care Collections Fund (MCCF) and authorized VA to retain collections from health insurers and veterans copayments at the local medical center/VISN level. Prior to this law, these collections, less administrative costs, were returned to the Department of Treasury.

Public Law 105-33 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. VA had used average cost-based per diem rates for billing insurers. Reasonable charges are calculated for inpatient facility charges, outpatient facility charges, and professional or clinician charges for inpatient and outpatient care.

Since inception, VA collections have increased from \$24 million in FY 1987 to an estimated \$750 million in FY 2001. We have made improvements in our operating

processes and systems through the years. We have taken what was a very labor intensive manual process and automated much of the billing and collections. We have provided automated processes such as pre-registration, claims tracking, autobiller, and several data capture initiatives, as well as enhancements to the integrated billing and accounts receivable packages in the Veterans Health Information Systems and Technology Architecture (VistA) to assist in billing and collections activities. The changes to the VistA system have replaced the majority of the manual processes once utilized. However, additional changes are still necessary to fully automate our billing and collection process.

Insurance Identification

Historically, approximately 15 percent of the total enrolled veteran population has reported billable health insurance. Through July of FY 2001, our efforts have increased that number to over 20 percent. We are actively pursuing a search for a private sector vendor to provide assistance with insurance identification. Further, we are preparing revisions to our health benefit application forms designed to encourage full disclosure by veterans of their insurance coverage.

Approximately 70 percent of the health insurance policies reported are Medicare supplement policies. Reimbursements from these policies are extremely low, and law prohibits VA from billing Medicare and Medicaid directly. HMO's and some PPO's reimburse VA only for emergency services and not for the provision of routine health care services.

Billing and Collection

Billing reasonable charges is time consuming and the accuracy of documenting the medical care provided on the bill is critical. The effectiveness of billing reasonable charges relies upon consistent application of sound business practices and compliance with policies and procedures. Billing and collections is the final component of a process that includes patient registration, insurance identification and verification, documentation of care provided, inpatient and outpatient coding of care received, utilization review, and

billing and accounts receivable. All of these components must work together for timely and accurate bills to be produced.

The July 10, 1998 “Audit of the Medical Care Cost Recovery Program” conducted by the Office of Inspector General (OIG) determined that Veterans Integrated Service Network (VISN) Directors could enhance MCCR recoveries by requiring facilities to (1) use management tools to identify and bill insurance carriers more timely, (2) more aggressively pursue collection of accounts receivable, (3) establish and monitor performance standards for MCCR staff, and (4) demonstrate how MCCR recoveries benefited the veteran.

A close review of collections from FY 1998 to FY 2000 showed that reported collections increased only slightly from FY 1998 to FY 1999. In FY 2000, 12 of the 22 VISNs did not meet their goals, and 10 of the 22 VISNs collected less in FY 2000 than in FY 1999. As a result, collections in FY 2000 were slightly lower than in FY 1999. This was due in large part to the implementation of Reasonable Charges. Billing for reasonable charges increased workload and required significant training at the medical facilities. Billing and collection activities at some facilities, therefore, decreased during this implementation phase. However, with full training of staff, collections for FY 2001 have increased significantly.

Standardization

VHA’s strategic change to reasonable charges using standardized forms (UB92 and HCFA 1500) supports the larger initiative of improving compliance with all requirements and standards (both VA and non-VA). Compliance will also require improvement to VHA’s patient accounting system. VHA’s Office of Information (OI) continues to modify our information system to meet current requirements. Concurrently, OI is addressing the impact of future requirements and standards, such as those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), on its processes and information systems. The law mandates that standard electronic transactions be used to accomplish electronic exchange of health care information. In particular, HIPAA sets standards for certain health transactions, including claims, enrollment, eligibility, payment, and coordination of benefits. HIPAA also sets standards to address security

and privacy of electronic health information systems. Providers and health plans are required to use the standards for electronic transmissions within 24 months after they are adopted as law.

As one critical step to improve collections, the VistA system must be transformed into an “account-based” system. This means that in addition to a permanent, global patient identifier such as a medical record number or social security number (SSN), a patient account number for billing purposes should be assigned for each episode of care that a patient receives. Generally, an episode of care is defined as any of the following: an inpatient stay, a visit to the emergency room, a one-time visit to an outpatient clinic, or a set of recurring visits to an outpatient service area for such treatment as physical therapy or dialysis. One patient may have multiple patient account numbers or indirect global data elements such as SSN, medical record number, guarantor number, and enterprise record number. These features are foreign to the way that VistA operates today. While it appears that the equivalent of an account number may exist among the VistA Patient Care Encounter (PCE), Patient Treatment File (PTF), and Claims Tracking applications, the extent to which VistA may need to be modified to effectively support account-based functionality has not yet been fully determined.

The complexities brought about by VA’s change in billing and collection have greatly impacted the information systems that support the revenue cycle operations, necessitating a modernized patient accounting system. VistA, VHA’s information system, is an integrated set of approximately 130 modules with primary focus on clinical applications. All of VistA is developed and maintained by VHA. In this dynamic environment, VHA must consider whether continuing to develop and maintain a patient accounting system supports its core mission. VistA applications used to support the revenue cycle process have fundamental weaknesses that prohibit seamless, automated claims generation. The information technology weaknesses that most contribute to problems with claims generation and improved performance have been defined as critical weaknesses. These weaknesses adversely affect functionality and performance, and we believe that we must replace our current billings and collections software with a fully functional Commercial-off-the-Shelf (COTS) patient accounting system.

Outsourcing Healthcare Revenue Collection

I do understand that there is a great deal of interest in the issue of whether we outsource certain aspects of our Revenue Cycle. The improvement plan that has been prepared does not preclude us from considering outsourcing certain aspects of the five core processes immediately, if that is found feasible and optimal. The improvements we need to make to VistA, though critical to future considerations of the direction we may take, certainly will not keep us from considering any outsourcing until the improvements are made. I do want to stress, however, that any decision we make will be based on sound economic analysis.

As you know, we have attempted to outsource and/or consolidate parts of the Revenue process through the Health Care Revenue Collection Pilot projects. These projects were controlled tests to evaluate the implementation and outcomes of redesigned revenue collection models in four VISNs. Although we have not had much success, we have learned a great deal. In particular, it is clear that IT issues are critical. We have been unable to implement some projects due to problems surrounding interfaces, programming, firewalls, and security. Ultimately, these issues will be addressed. However, they currently limit our ability to conduct meaningful short-term outsourcing options. As with all other major decisions we make concerning revenue, future outsourcing decisions will be made with the ultimate goal of maximizing net revenue collections.

National consolidation and outsourcing represent possible solutions to enhance the performance of the VHA revenue cycle. Such solutions are predicated on effective, high performing “front-end” revenue cycle processes. We are responsible for and need to improve those processes, which include patient intake, insurance identification and verification, case management, documentation, and coding functions. Our long-term strategy includes determining the viability of outsourcing all aspects of billing and accounts receivable as well as the patient financial/accounting system. The recommended actions prescribed within our Revenue Cycle Improvement Plan would enable us to move in this direction.

Revenue Cycle Improvement Plan

Our Revenue Cycle Improvement Plan identified 24 actions (see Attachment) to improve the core business processes of the revenue cycle. These action items fall within five process areas: Patient Intake, Documentation, Coding, Billing, and Accounts Receivable (AR). Many of the actions will require solutions to long-standing problematic areas of the Revenue program.

Of the 24 proposed actions, the following five are critical to the overall success of the plan:

- Implement **electronic insurance identification and verification** – an online system that verifies existing insurance policy coverage and establishes insurance coverage data when none is provided.
- Create **education programs** for veterans, clinical, and administrative staff – stress importance of accurate and complete data and monetary benefits from collection of insurance information.
- Mandate the **use of encoder and claims analyzer software** – to create a “clean and accurate” bill and to meet latest coding standards.
- **Consolidate/outsource 3rd Party Accounts Receivable (AR) follow-up** – to eliminate backlog and aggressively pursue payment from insurance carriers on aged claims to insurance carriers.
- **Standardize documentation policy** to assure that claims meet current industry standards and are complete and accurate.

Accountability, responsibility, and authority for performance and outcomes will begin at VHA Central Office and will be established for VISN and facility leadership. VHA will provide policy direction, national program support, and provide oversight for efforts at all levels. Leaders and managers at all levels will be accountable for Revenue Program results. VHA is taking immediate action in the following four core elements:

- communicating the priority of the plan’s recommended actions;
- assembling integrated project teams (IPTs) composed of cross-functional VHA staff from the field and Central Office;
- having the IPTs recommend a comprehensive, detailed project plan for each specific recommended action; and

- forming a Central Office Revenue Team (CORT) to assist VISN and VAMC staff with improving revenue cycle performance

Conclusion

We project that, under our improvement plan, collections will reach \$1.4 billion by FY 2005. We intend to aggressively implement the Revenue Cycle Improvement Plan to assure that we reach this level of revenue collections. This effort will be characterized by clear assignment of management responsibility and accountability for performance, improved information systems, increased level of staff competencies, and consistent application of policy across the system.

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

Attachment

Revenue Cycle Improvement Plan

The 24 action items are:

1. Mandate pre-registration of veterans
- Besides simply reminding a patient of an upcoming appointment, the pre-registration process enables VHA to verify and/or update current demographic information and insurance.
2. Define standards for complete and accurate data capture/registration
 - Requires VHA to establish national policy defining the requirements for complete and accurate patient data capture.
3. Develop and implement veteran education program
 - Requires the development and implementation of an educational program designed to inform veterans of the benefits of collection and dispel myths about negative impact to them.
4. Develop and implement VHA employees education program
 - Requires the development and implementation of an educational program specifically for VHA employees who are required to obtain patient data on a daily basis.
5. Implement electronic insurance identification and verification
 - There are products available today that are specifically designed to assist health care organizations identify and verify patient insurance information via Electronic Data Interchange (EDI) technology.
6. Consolidate insurance information at the enterprise level
 - Establish a national resource for identifying and verifying patient insurance information as well as limit redundancies in patient intake activities nationally.
7. Develop an employer master file
 - Facilities would maintain a file of employer information and insurance information.
8. Enforce national documentation policy (M-1, Part 1, Chapter 5)

- Requires VHA to define the required data elements for patient encounters, enforce the national documentation policy.
9. Mandate use of electronic medical records (CPRS)
 - Requires VHA mandate the full and complete use of the electronic medical record such as the Computerized Patient Record System (CPRS).
 10. Develop national clinical education program
 - Requires the development and use of a national clinical education program to improve timeliness of documentation to support billing.
 11. Develop and mandate use of electronic encounter form & documentation template
 - Develop standardized electronic encounter forms for use in the CPRS system that can be used throughout VHA by clinicians.
 12. Develop and implement documentation tracking system
 - Allow VHA to monitor timely completion of documentation.
 13. Develop staffing plan for coding resources
 - Requires the development of a staffing plan for coding to address current staffing deficiencies.
 14. Mandate use of encoder software
 - Provides online reference assistance and suggestions to assignment codes based on clinician documentation.
 15. Develop national standard for laboratory, radiology, and other ancillary test names and corresponding CPT codes
 - Mandate system-wide use of the clinical applications to capture patient services and documentation of patient care and billing information.
 16. Mandate minimum access policy to VistA ancillary packages
 - Allow billing staff minimum access to specific VistA ancillary packages.
 17. Complete implementation of EDI Billing and MRA projects
 - Implementation of EDI and MRA would decrease bill lag time, improve claim accuracy, and reduce bill payment cycle.
 18. Implement “claims analyzer” tools
 - Requires the implementation and system wide use of a claims analyzer tool.

19. Improve the charge capture process
 - Accurate and timely claims can only be generated when all charges are captured, are known to the billing system and relate to an episode of care.
20. Consolidate/Outsource VHA 3rd party accounts receivable follow-up
 - Requires VHA to implement and nationally mandate a consolidated approach for follow up on 3rd party accounts receivables.
21. Develop utilization review (UR) program
 - Requires development of a national education program that provides specific skill sets to help UR nurses support the revenue cycle.
22. Request VA General Counsel more aggressively pursue “referred” third party accounts receivable
 - The Revenue Office will work diligently with VA General Counsel to determine the appropriate course of action for “referred” 3rd party accounts receivable.
23. Implement 3rd party payment and remittance program (EDI Lockbox)
 - Enables the transmission of insurance payments to VHA through a contracted commercial financial institution for payment processing.
24. Implement accounts receivable management software
 - Requires VHA conduct a national implementation of accounts receivable management software and mandate its use by all facilities.

The plan includes performance measures that will be key indicators of performance and improvement.

They are:

1. Percentage of patients pre-registered
1. Percentage of completed registration
2. Percentage of insurance verified prior to discharge
3. Percentage of encounters with electronic notes
4. Bill lag time
5. Percentage of 3rd party AR greater than 90 days
6. Cost to collect
7. Total collections

