United States General Accounting Office

GAO

Report to the Ranking Minority Member, Committee on Veterans' Affairs, U.S. Senate

April 1990

VA HEALTH CARE

Better Procedures Needed to Maximize Collections From Health Insurers

GAO/HRD-90-64

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-237001

April 6, 1990

The Honorable Frank H. Murkowski
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Murkowski:

In response to your request, this report addresses the Department of Veterans Affairs' collections from health insurers for the cost of care provided to certain insured veterans.

Basically, we found that collections from insurers greatly exceeded the cost of collection. But we estimated that the Department had collected from insurers only about one-third of the possible collections for medical services provided to insured veterans.

Unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time we will send copies to the Secretary of Veterans Affairs and other interested parties. The report was prepared under the direction of David P. Baine, Director, Federal Health Care Delivery Issues. If you have any questions, you may call him on (202) 275-6207. Other major contributors are listed in appendix XI.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

The Department of Veterans Affairs (VA) spends about $10 billion annually providing health care to veterans, including those who have private health insurance coverage. To help reduce the federal budget deficit, in 1986, the Congress established the right of the United States to collect from health insurers the cost of care provided to certain insured veterans.

The Ranking Minority Member of the Senate Committee on Veterans' Affairs asked GAO to determine whether VA's collections from health insurers exceeded its collection costs. He also asked whether VA had effective procedures to (1) identify insured veterans, (2) bill insurers, and (3) collect amounts owed.

Background

VA, with 159 medical centers, operates the largest health care delivery system in the United States. In response to the 1986 legislation, VA directed its medical centers to bill insurers for inpatient care costs. But VA allowed medical centers to decide whether to bill insurers for outpatient care.

To assess VA's billing and collection procedures, GAO visited six centers and reviewed records of randomly selected insured veterans who received care during 6 months of fiscal year 1988. GAO also sent a questionnaire to all VA medical centers to obtain information on their identification, billing, and collection procedures, as well as costs.

Results in Brief

Collections greatly exceeded costs. In fiscal year 1988, VA spent about $8 million to collect about $100 million from health insurers. About $96 million of these collections was attributable to inpatient health care; the remainder, to outpatient care.

GAO estimates that VA collected from insurers only about one-third of the possible collections for medical services provided to insured veterans. VA centers could increase collections significantly if they (1) employed more effective methods to identify insured veterans and bill insurers and (2) committed additional resources to collection efforts. Centers are reluctant to make such a commitment because (1) all amounts collected must, by law, be returned to the U.S. Treasury and (2) additional collection costs centers incur are paid from their existing medical care budgets.

Principal Findings

GAO Estimates VA's Collections Potential

GAO estimates that VA could have collected an additional $223 million from insurers in fiscal year 1988, about $180 million for inpatient care and about $43 million for outpatient care.

Data limitations introduce considerable uncertainty into the $223 million estimate, but GAO believes that additional collections could have been at least $55 million and perhaps as much as $392 million. (See ch. 2.)

Insured Veterans Not Always Identified

In four of the six centers visited, GAO found veterans admitted for inpatient care who had private insurance policies not identified by VA. These veterans made up 15 percent of the total identified by both VA and GAO during the periods GAO sampled. VA could have billed insurers about $318,000 for these veterans' care. Center officials offered several explanations for these missed billings, including (1) center admissions staffs' failing to ask the right questions or (2) veterans being confused or afraid that disclosures about insurance would jeopardize their admittance to the centers.

The centers could have identified these veterans if their processes had included steps to verify the information the veterans provided, such as reviewing administrative and medical records or contacting employers. Nationwide, about two-thirds of VA's medical centers reported that they did not verify veterans' statements about insurance coverage. (See ch. 3.)

Inpatient Care Costs Not Always Billed

Even when centers identified insured veterans, they did not always bill insurers. Five medical centers GAO visited did not bill $1.8 million of the $7 million in inpatient care costs during the first 6 months of fiscal year 1988; GAO did not assess inpatient billings at one center visited. Billings were missed because the centers relied on manual systems that were flawed. For example, billing staffs were not notified when insured veterans were discharged, and internal controls were inadequate to detect the missed billings. (See ch. 4.)

Outpatient Care Costs Rarely Billed

Three medical centers GAO visited did not bill for any outpatient care, and the other three billed for such care only under certain conditions. GAO estimates the six centers did not bill insurers for about $1.6 million during the first 6 months of fiscal year 1988; an estimated $200,000 was billed. Nationwide, 66 centers reported they did not bill insurers for outpatient care, and 46 billed them for less than half of the outpatient care provided in fiscal year 1988. (See ch. 5.)

Medical Centers Did Not Commit Resources Needed

Of the 159 centers, 122 reported that adequate resources were not available to collect all health care costs from insurers in fiscal year 1988. Officials at the centers GAO visited said that they would not commit additional resources to the recovery effort until they received additional resources from headquarters or were allowed to keep a portion of the collections. (See ch. 7.)

Recommendations

GAO recommends that the Secretary of Veterans Affairs ensure that all medical centers to bill for outpatient care. In addition, GAO recommends that the Secretary ensure that each medical center has

- effective procedures for (1) identifying all veterans with insurance and (2) billing insurers for all inpatient and outpatient care provided to insured veterans and
- sufficient resources to fully implement identification, billing, and collection procedures. (See ch. 7.)

Matter for Consideration by the Congress

Given the substantial benefit to the government possible through maximizing insurance collections, the Congress should ensure VA has adequate resources to fully implement its recovery efforts. If adequate resources are not available through the budget process, the Congress should consider amending 38 U.S.C. 629 to allow VA to keep a portion of the amounts collected from insurers to pay its collection costs. (See ch. 7.)

Agency Comments

VA agreed with GAO's recommendations and pointed out a number of actions it was taking to increase collections from health insurers, including establishing a recovery task force for medical care costs. The task force would be charged with developing a strategy to improve identification, billing, and collection procedures as quickly as possible.

VA recognized that additional funding is needed to properly carry out the billing and collection effort; it proposed legislation in its fiscal year 1991 budget request to provide that funding (see app. X).

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Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organizations
OMB	Office of Management and Budget
VA	Department of Veterans Affairs

1

The Department of Veterans Affairs (VA) operates the largest health care delivery system in the United States. The Veterans' Health-Care Amendments of 1986 established the right of the United States to recover the costs of health care provided to certain veterans covered by private health insurance. The Ranking Minority Member of the Senate Committee on Veterans' Affairs requested that we evaluate VA's recovery efforts.

VA's Health Care Delivery System

VA operates 172 hospitals, 233 outpatient clinics, and 119 nursing homes. Most of these medical facilities are organized into 159 medical centers throughout the United States. In fiscal year 1988, VA spent about $10 billion providing medical care to veterans, including about 1.1 million inpatient hospital stays and over 20 million outpatient visits.

Veterans eligible for medical care are classified into two broad categories: those with disabilities resulting from their military service and those without such disabilities. Veterans with service-connected disabilities are afforded the highest priority when seeking care at VA medical centers.

VA's Authority to Recover Health Care Costs

Before 1986, in specified circumstances, VA could recover the reasonable costs of care for treatment of nonservice-connected disabilities covered under a workers' compensation law, a state law concerning no-fault insurance, or a state or local program of compensation for victims of personal violence. In emergency cases, VA could also charge for hospital care or medical services provided to people otherwise ineligible for VA care.

VA could not recover from health insurers the cost of care provided to many privately insured veterans because most insurance policies had clauses barring reimbursement to VA facilities. In 1985, we recommended that VA be permitted to recover from health insurers the costs of care provided to privately insured veterans, except care related to service-connected disabilities.[1] The Veterans' Health-Care Amendments of 1986 (title XIX of P.L. 99-272), which became law in April 1986, authorized VA to recover the reasonable costs of care for the treatment of insured veterans who do not have service-connected disabilities (hereafter referred to as insured veterans). The cost of care provided to veterans

[1] Legislation to Authorize VA Recoveries From Private Health Insurance Would Result in Substantial Savings (GAO/HRD-85-24, Feb. 26, 1985).

who had service-connected disabilities could not be recovered, regardless of whether the care was related to a nonservice-connected condition.[2] The law specified that all funds collected by VA be returned to the U.S. Treasury.

The 1986 amendments authorized VA to receive payments from health insurers just as non-VA health care providers do, except that VA is prohibited from receiving Medicare or Medicaid payments. Insurers' payments to VA can vary considerably depending on the type of insurance. A health insurer generally pays the covered health care costs less the patient's coinsurance (percentage of expenses the patient must pay) and deductible amounts. The law prohibits VA from seeking reimbursement for any coinsurance or deductible amounts required by health plan contracts from insured veterans. Other types of insurers, such as health maintenance organizations, would pay VA for care in limited situations, for example, a medical emergency. Still other insurers pay the policyholders (with indemnity policies) fixed amounts per day of hospitalization.

VA's Insurance Recovery Process

Recovering from health insurers is a three-step process—identifying veterans with health insurance, billing insurers for care, and collecting amounts owed. Within each medical center, the medical administration service has responsibility for identifying insured veterans and billing for their care, and the fiscal service has responsibility for collecting unpaid bills and recording collected amounts. Counterpart units at headquarters give technical assistance and general guidance. Medical centers were given latitude to develop many of their own specific procedures for identifying insured veterans, billing insurers for care, and collecting amounts owed.

Each year, VA develops national daily billing rates, which cover all related costs of care, including room and board, physicians' costs, ancillary services, and all interest and support costs. VA calculates the amount to bill insurers for inpatient care by multiplying the number of days of care by the daily rate. Different inpatient rates are developed for specific types of care, for example, surgery or psychiatry. For outpatient care, VA charges a fixed rate. VA fiscal year 1988 and 1989 billing rates for most types of care are listed in appendix I.

[2]In March 1989, the Ranking Minority Member of the Senate Veterans' Affairs Committee introduced a bill (S. 573) that would authorize VA to recover the cost of care for nonservice-connected disabilities of insured veterans who also have service-connected disabilities. This change would be in conformity with GAO's 1985 recommendation to recover for such care.

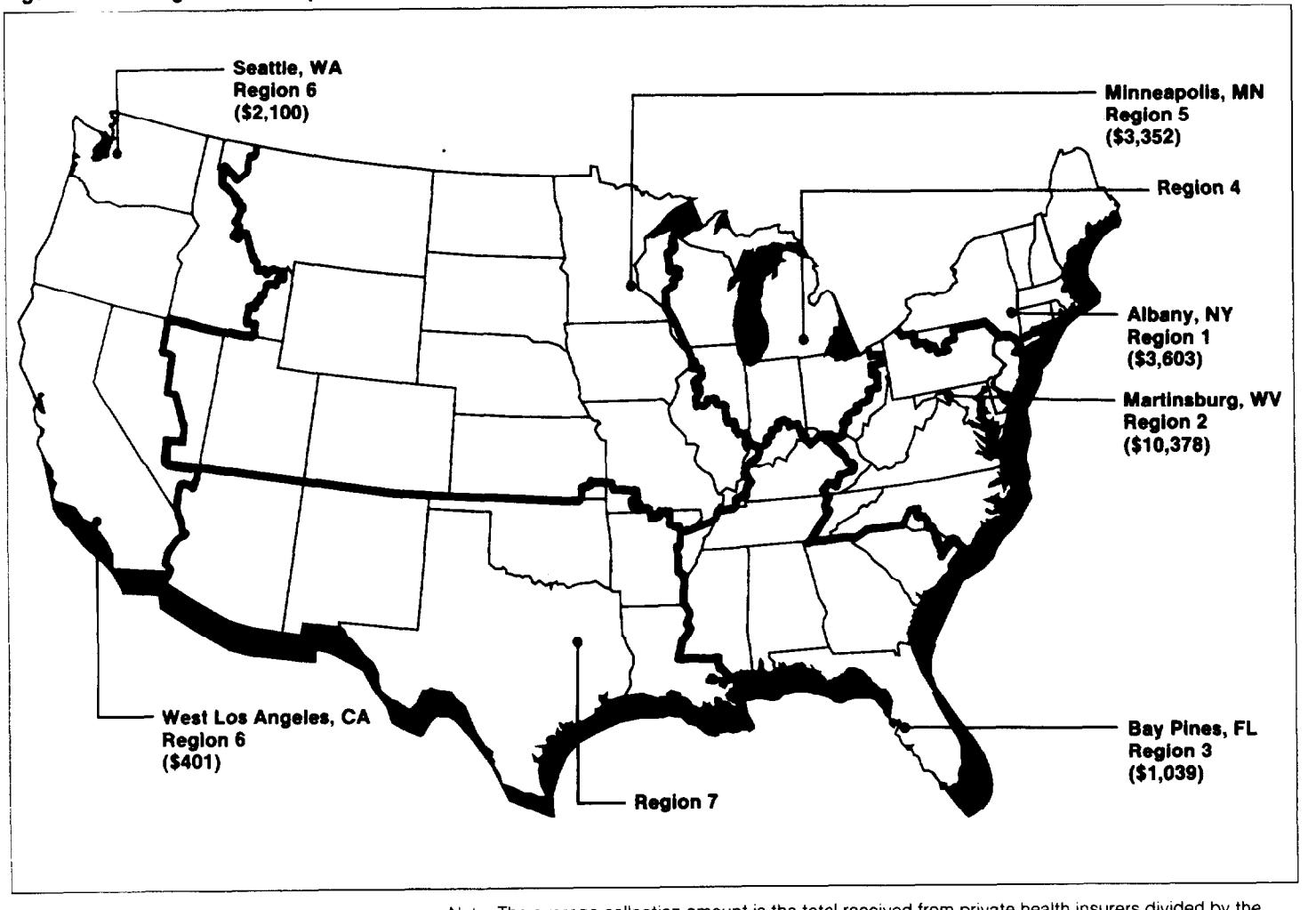
Objectives, Scope, and Methodology

Senator Frank H. Murkowski, Ranking Minority Member of the Senate Committee on Veterans' Affairs, asked us to determine whether VA's collections from insurers were exceeding its costs to collect. In addition, he asked us to evaluate whether VA had implemented effective procedures to (1) identify veterans with health insurance coverage, (2) bill insurers for all care provided to these veterans, and (3) collect amounts owed. In addition, we estimated VA's potential collections from health insurers nationwide in fiscal year 1988.

To accomplish our objectives, we (1) reviewed relevant policies, procedures, and studies and (2) interviewed VA officials at headquarters, regional offices, and medical centers. We also visited six medical centers to assess the effectiveness of VA's recovery process. The centers were judgmentally selected to gain a wide mix for several key factors, such as (1) size (number of beds), (2) settings (for example, rural or urban), and (3) collections per average daily occupied bed.[3] Appendix II contains fiscal year 1988 information on the factors considered for each medical center. As shown in figure 1.1, the centers were located in five of the seven VA medical regions.

[3]We used collections per average daily occupied bed rather than total collections because the average daily collection incorporated the size of the center into the assessments.

Figure 1.1: Average Collection per Bed From Private Health Insurers at VA Medical Centers GAO Reviewed (Fiscal Year 1988)



Note: The average collection amount is the total received from private health insurers divided by the average number of occupied beds. The average collection amount for all medical centers was $1,910.

At each of the six medical centers, we interviewed officials in the office of the director, medical administration service, and fiscal service to discuss the internal control procedures for identifying insured veterans, billing insurers for care, and collecting from insurers. We also discussed factors that aided or impeded the centers' recovery efforts.

To test the effectiveness of each center's procedures for identifying insured veterans, we worked with staff at five of the centers to conduct a special record review for veterans (1) without service-connected disabilities and (2) admitted to the centers but not identified as having

insurance.[4] The review focused on identifying key indicators of insurance, such as employment, income, or previous insurance coverage. If possible insurance coverage was indicated, we asked the VA reviewer to interview the veterans before they were discharged to determine whether they had insurance. The test period at the five centers ranged from 14 to 35 days, depending in part on the availability of center staff to conduct the review.

To assess each center's billing and collection procedures, we reviewed medical and administrative records for a random sample of about 30 insured veterans from each of two universes:[5]

- veterans discharged from inpatient care between October 1, 1987, and March 31, 1988,[6] and
- veterans provided outpatient care between October 1, 1987, and March 31, 1988.

For those patients sampled, we documented (1) whether the medical center billed for all episodes of care provided to insured veterans and sent the bills promptly, (2) how much the center collected, and (3) the reasons for collecting less than the full amount. We contacted the staff of VA's district counsel, which served several of the medical centers, to discuss the policies and procedures for dealing with insurance cases referred to them.

We used our sample results to project the value of inpatient and outpatient care not billed by the medical centers. For our projections, which are for the first 6 months of fiscal year 1988, we used a 95-percent confidence level. Because our estimates are based on samples, sampling errors are associated with them.

To assess whether VA's collections from insurers exceeded its costs to collect, we used a questionnaire for information on (1) the medical centers' estimated staffing costs and (2) the amount of collections attributed to inpatient and outpatient care. We asked each of the 159 centers to complete a questionnaire because VA does not routinely collect these

[4]The sixth center, Martinsburg, was already using this special record review to identify insured veterans.

[5]We did not include veterans with indemnity policies or health maintenance organization coverage as insured veterans because of the limitations in reimbursement.

[6]At the Albany Medical Center in New York, we limited our review of veterans' records to veterans who received outpatient care.

data. All centers (1) identified by grade the staff responsible for billing and collecting from insurers and (2) estimated the average amount of time spent on recovery efforts for inpatient and outpatient care during a typical week in fiscal year 1988. We used the government salary rates to compute the staffing costs for this typical week and multiplied the costs for each center by 52 weeks to estimate the annual staff costs of VA medical centers in fiscal year 1988. The centers also estimated the percentage of their total collections that were related to outpatient care. Using these percentages, for each center, we estimated the amount of collections attributed to inpatient and outpatient care.

We also used the questionnaire to collect a broad range of information on each center's identification, billing, and collection policies and procedures. To gather information on industry norms and standards for billing and collection procedures, we contacted the Healthcare Financial Management Association, a professional society of health care financial executives, and visited a private hospital in Seattle.

To estimate VA's potential collections from insurers nationwide in fiscal year 1988, we obtained data from VA's 1987 Survey of Veterans.[7] On the basis of survey respondents' reported health insurance coverage and use of VA health care facilities, we estimated the total number of episodes of inpatient care and outpatient visits made by veterans with health insurance coverage. By applying to these estimates VA's reported average length of inpatient stays and daily rates for inpatient and outpatient care, we estimated the total amounts potentially billable by VA for this care. We reduced the total amounts potentially billable to allow for uncollectible amounts because of insurance policy limitations, such as deductibles and copayments.

Our review was carried out from December 1987 through June 1989 in accordance with generally accepted government auditing standards.

[7]A national survey of veterans conducted for VA by the U.S. Bureau of the Census to assess veterans' status and well-being.

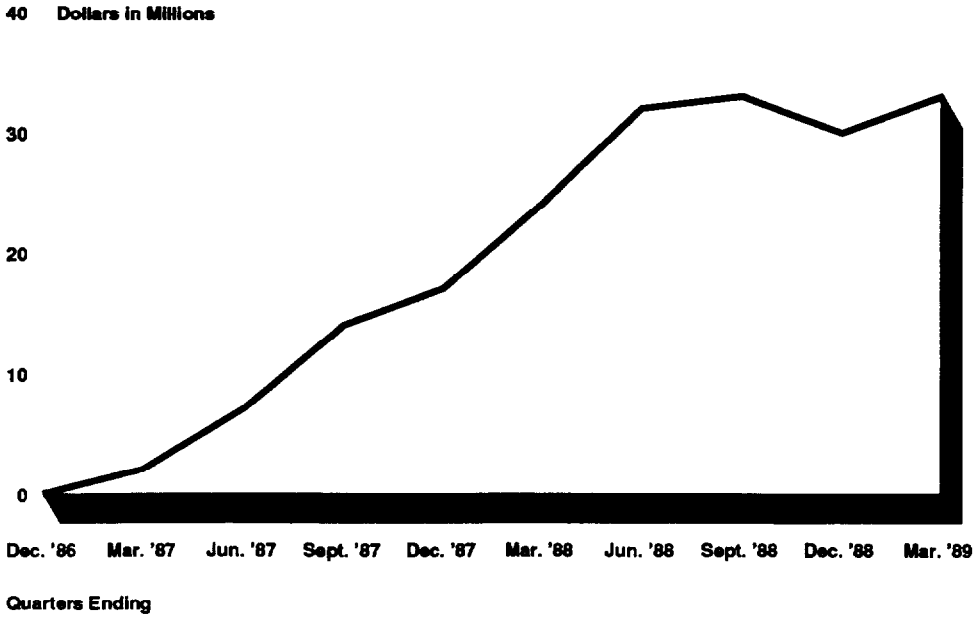
VA Has Not Maximized Its Insurance Collections

VA's collections from health insurers exceeded its costs in fiscal year 1988. But GAO estimates that the medical centers' collections should have been significantly higher. Policy decisions and ineffective collection procedures at the centers contributed to missed collection opportunities. To maximize collections, medical centers should (1) begin billing insurers for all outpatient visits and (2) develop better procedures to identify veterans with insurance and to ensure that all episodes of care are billed.

VA's Collections Exceeded Costs

The 159 medical centers spent about $8 million to collect $100 million in fiscal year 1988. VA medical centers reported insurance collections of $24 million in fiscal year 1987, the first full year in which VA collected from insurers. The reported collections increased to $100 million in fiscal year 1988, and collections started to level off during the last quarter of the fiscal year. Compared with fiscal year 1988, collections have remained relatively constant during the first 2 quarters of fiscal year 1989, as shown in figure 2.1.

Figure 2.1: VA's Collections From Health Insurers by Quarter (Oct. 1986-Mar. 1989)



Note: VA collected $302,000 in the quarter ending Dec. '86.

The medical centers have spent a relatively small amount of money to collect from insurers. On the basis of the information that centers submitted, we estimate that during fiscal year 1988, they spent about $8 million in staffing costs to bill insurers and to collect amounts owed. Although some centers reported other costs, such as for postage, the staffing costs were the vast majority of the reported costs. Given these reported collections and costs, on a nationwide basis, VA collected about $12 for every $1 spent on medical center staff.[1]

Most of the collections—$96 million of the $100 million—came from inpatient care. This represents a return of $16 collected for each $1 spent on medical center staff. By comparison, centers' collections for outpatient care were an estimated $4 million because VA did not direct centers to bill insurers for such care. Most centers reported that in fiscal year 1988, they either billed insurers for outpatient care on a limited basis only or did not bill. Nonetheless, the centers collected, on average, about $2 for each $1 spent on staff costs for billing. The years when centers began billing insurers for outpatient and inpatient care is shown in appendix III.

VA has conducted a pilot study at the Martinsburg Medical Center that may provide a more accurate indication of the payback potential of billing for outpatient care. VA headquarters authorized three staff positions for this study,[2] which began on August 22, 1988. Through March 31, 1989, Martinsburg had collected about $74,000 from insurers and spent about $18,000 on personnel costs, a return of over $4 for each $1 spent. Like most other medical centers, Martinsburg has not billed for all outpatient care provided, but the collections-to-cost ratio at Martinsburg has been increasing as the center has gained experience in billing insurers for such care.

[1]VA's reported collections for fiscal year 1988 could include some receipts for bills sent in fiscal year 1987. In addition, collections for some bills sent in fiscal year 1988 may be included in VA's fiscal year 1989 reported collections. We believe that this will not materially affect the results of our analysis because the amounts involved would tend to offset each other.

[2]These staff, the chief of insurance billing said, also spent time preparing other types of bills. The cost amounts shown here are the costs associated with the portion of staff time spent on billing insurers for outpatient care.

GAO Estimates Additional Collection Potential

On the basis of our work at six centers, we could not estimate potential collections from insurers nationwide. We, therefore, estimated VA's potential collections from insurers on the basis of veterans' responses to VA's 1987 Survey of Veterans. The survey asked veterans about their insurance coverage and the extent to which they received inpatient and outpatient care at VA facilities.

Using veterans' responses to these questions, as well as average length of inpatient stays reported by VA and VA's daily rates, we estimate that VA could have collected about $323 million from insurers in fiscal year 1988. Of this amount, about $276 million was attributable to inpatient care and $47 million to outpatient care. Given VA's collections of $100 million, we estimate that VA could have collected an additional $223 million—$180 million for inpatient care and $43 million for outpatient care.

Limitations in the available data cause considerable uncertainty in estimates of potential collections. Nevertheless, we believe VA could have increased collections by at least $55 million and perhaps as much as $392 million. Our method for estimating VA's potential collections from insurers is discussed in appendix IV.

Policy Decisions and Ineffective Procedures Limited VA's Collections

VA did not bill insurers for millions of dollars because of (1) weaknesses in procedures at the medical centers or (2) policy decisions not to bill insurers for all outpatient care provided. The weaknesses in procedures at the centers we visited resulted in centers not

- identifying all veterans who had insurance coverage,
- billing insurers for all episodes of inpatient care provided to insured veterans, and
- collecting all that they should have even when the care was billed.

We believe, on the basis of centers' responses to our questionnaire, that these six centers are not unique. In response to our questionnaire, many other centers reported procedures similar to those used at the centers visited. In the following chapters, we discuss in more detail the procedures used.

Need to Improve Identification Procedures at the Medical Centers

Of five medical centers visited during our test period of 14 to 35 days, four did not identify all veterans with insurance. We reviewed available data and found that the centers had not identified many insured veterans during the initial admissions screening. As a result, the centers missed billing insurers for over $300,000 in care provided to these veterans during that period. This problem may be widespread since many other medical centers, in responding to our questionnaire, said they did not review available data after the initial admission screening to identify insured veterans.

Medical Centers Visited Not Identifying All Insured Veterans

During the initial admission screening, each veteran requesting medical care must complete an application for care.[1] This application contains a number of questions designed to gather basic data about the veteran, including whether he or she has health insurance. In identifying veterans with insurance, of the six medical centers we visited, five relied mainly on information that the veterans gave during the initial screening process.

To test the effectiveness of each center's procedures for identifying insured veterans, we did a special review, during our site visits, of the records of veterans admitted to the five centers, but not identified as having insurance. The review focused on identifying key indicators of insurance, such as employment, income, or previous insurance coverage. When we found these indicators, we asked the VA reviewer to interview the veterans before they were discharged to determine whether they had insurance.

We did not do a special review at the Martinsburg Medical Center, in West Virginia, because this center routinely did such a review. Our random sample of 32 insured veterans admitted to Martinsburg included 6 identified by the center's special review as having insurance. If Martinsburg relied solely on the initial screening process, these veterans would have been missed. On the basis of these sample results, we estimate that the insured veterans identified through this review received an estimated $864,000 of the medical care billed during only the first half of fiscal year 1988. Martinsburg officials have found that this review continues to be an effective way to identify insured veterans. The chief of insurance and billing, whom we asked to record the results of this

[1] At some medical centers, veterans complete the applications and the medical center staff later enter the information into the center's computer system. At other centers, medical administration service staff interview veterans and enter the information obtained directly into the computer system.

review during a 4-month period in fiscal year 1989, reported that she identified 27 insured veterans. These veterans received almost $225,000 of care that the center billed to insurers.

The other centers we visited identified 30 insured veterans during the test period; these veterans had not been identified as having insurance during the initial screening process. They received about $318,000 of inpatient and outpatient care that the centers should have billed to insurers. Although the centers would probably not have collected the total amount billed because of insurance deductibles and coinsurance requirements, we believe that the results indicate significant additional collection opportunities, especially given the limited test period. Our test results are shown in table 3.1.

Table 3.1: Insured Veterans Identified During GAO Visits to Medical Centers

Center	Days test conducted	Insured veterans identified through existing procedures	Additional insured veterans identified through test procedures	Value of additional veterans' medical care
Minneapolis	23	43	16	$121,317
Bay Pines	27	57	2	77,597
Albany	14	18	6	76,809
West Los Angeles	35	30	6	42,656
Seattle	19	22	0	0
Total	**118**	**170**	**30**	**$318,379**

Supervisors and managers at the centers could not tell us conclusively why veterans with insurance were slipping through the initial screening process, but they offered two potential reasons. Not all clerks, said the processing unit (admitting area) supervisor at one center, ask veterans about their insurance coverage each time they are admitted to the center, even though the clerks should; if the veterans have applied for care in the past and previously indicated no insurance, the clerks do not always ask whether the veterans currently have insurance coverage. As a result, the information obtained may not be complete and accurate. In addition, center staff have suggested, veterans may not answer questions about their insurance accurately, even if asked, because they (1) are confused or (2) fear that disclosure of insurance will affect their access to free health care at VA medical centers.

We believe our test understates additional collection opportunities at the centers because veterans' applications were often incomplete. For example, at the medical center in Seattle, the employer was shown as "unknown" in 81 percent of the applications we reviewed during an 8-day period.[2] The lack of employment information reduced our chances of identifying additional veterans with insurance.

We also found missing data at other centers we visited. For example, at three centers, from 50 to 69 percent of the applications for our sample of veterans were missing employment information. This information is useful because many employers or former employers provide health insurance coverage, and employment information can serve as an indicator of insurance. At the West Los Angeles Center, the insurance coordinator did a special review of applications to evaluate the effectiveness of the initial screening process as a method of gathering information. In reviewing applications for a 32-day period, he found that 56 percent were missing employment information.

After we did our test at the West Los Angeles Medical Center, the center successfully used the special review to identify additional insured veterans. The insurance coordinator reported that in December 1988, several months after the test period, 24 insured veterans were admitted to the center. The admissions staff identified 11 of these veterans. The insurance coordinator said that he identified the other 13 veterans by conducting a special review of veterans' records and interviewing veterans, employers, and insurance companies.

Other Medical Centers Using Special Reviews

Centers other than the six we visited also reported success with the special review. We contacted several of the medical centers that had reported, in their responses to our questionnaire, that they reviewed veterans' records for indicators of insurance coverage. The medical center in Bonham, Texas, according to a center official, using this special review, identified 25 percent of all veterans with insurance. By using this review, an official at the medical center in Chilicothe, Ohio, said, the center significantly increased its collections. However, the center did not record the number of insured veterans identified using this special review.

[2]For 8 days during our 19-day test period, we reviewed the records to determine how many contained employer data.

Despite the usefulness of the special review, VA had not required centers to use it, at the time of our review, and most centers were not doing so. On the basis of responses to our questionnaire and follow-up conversations with medical center officials, we estimate that about two-thirds of the centers were not reviewing the records of "uninsured" veterans to check for indicators of possible insurance.

Centers Need Better Billing Procedures to Recover the Costs of Inpatient Care

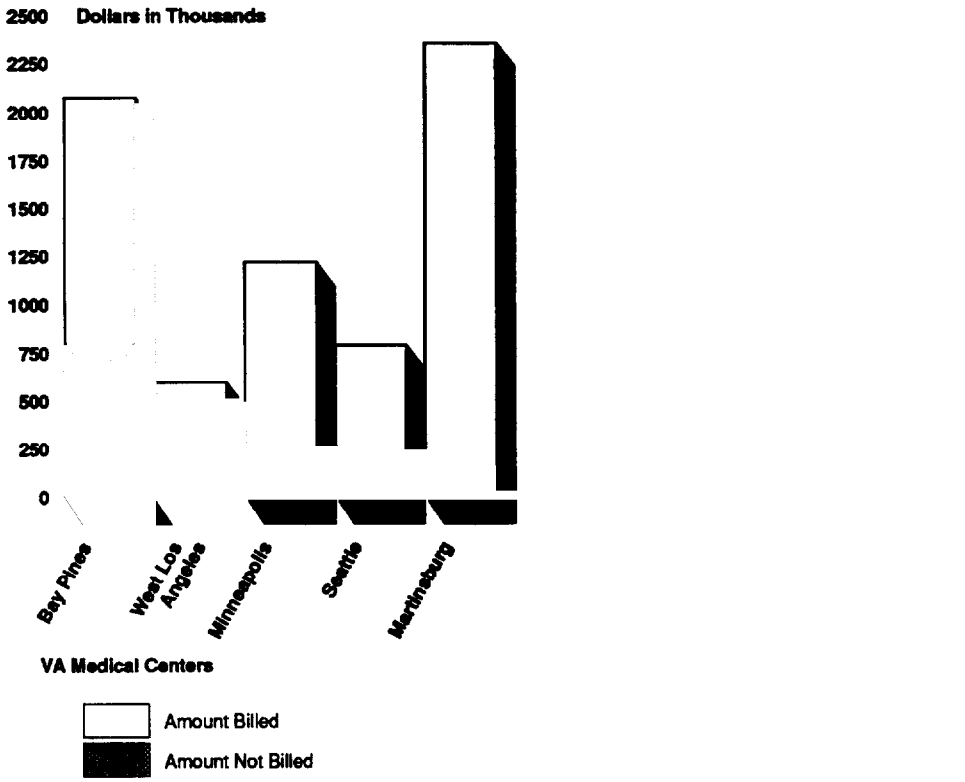
The VA medical centers we visited were often not billing insurers for care because of ineffective procedures. During the first half of fiscal year 1988, we reviewed inpatient billing for five centers; these centers missed billing insurers for about $1.8 million.[1] In addition, bills, when sent, were rarely processed promptly, resulting in additional lost revenue to the government.

Medical Centers Missing Substantial Billing Opportunities

Even when medical centers identified veterans as insured, the centers did not always bill insurers for all episodes of care provided. At five centers, we reviewed random samples of insured veterans who were discharged from inpatient care during the first 6 months of fiscal year 1988. On the basis of this review, we estimate that these centers should have billed insurers for approximately $7 million of inpatient care instead of the $5.2 million we projected they billed. Our projections for each center of the billed and unbilled amounts for insured veterans are shown in figure 4.1. Appendix V contains more detailed information on our methodology.

[1]There is a 95-percent chance that the true value for the population lies between $1.2 and $2.3 million.

Figure 4.1: Projected Value of Inpatient Care Provided to Insured Veterans (Oct. 1987-Mar. 1988)



We cannot project how much the five centers would have collected had they billed insurers for these additional amounts; however, the centers could collect about $850,000 if, for the veterans in our samples, the collection rates for the unbilled care were the same as for the billed care. As discussed in chapter 6, we believe these collection rates and the corresponding dollar recoveries could be increased with improved procedures.

Nationwide, we estimate that medical centers could have collected another $29 million to $332 million from insurers for inpatient care in fiscal year 1988 (see ch. 2).

Internal Controls Lacking to Prevent Missed Billings

Four of the five centers had problems with inpatient billing procedures, as indicated by the amount of missed billings we found. The centers used varying procedures to notify billing staffs about care provided to insured veterans. However, three centers with high missed billings relied mainly on admissions or insurance clerks to notify billing staff when insured veterans were admitted. These centers lacked basic internal controls as a backup system to help ensure that all cases were billed. Hence, when admissions or insurance clerks, for whatever reasons, did not carry out their responsibilities to notify billing clerks, care was not billed, for example:

- At the West Los Angeles Medical Center, an insurance coordinator was expected to (1) verify insurance coverage for veterans identified as having insurance and (2) then send a notification to the billing staff. Because the applications and insurance information forms were often not available, the coordinator said he was unable to notify the billing staff that some insured veterans were receiving care. For example, during a 26-day period, the administrative folders or insurance forms were unavailable for 65 percent of the insured veterans admitted to the center. The center's quality assurance staff, who previously carried out some of the insurance coordinator's functions, agreed that the inability to locate veterans' medical records promptly directly contributed to missed billings.
- At the Minneapolis Medical Center, the admitting staff were supposed to send a notification to the insurance clerk when insured veterans were admitted, and the clerk was then to notify the billing staff. For 4 veterans in our sample of 36, insurers were not billed using these procedures, even though the veterans' insurance coverage was identified when they were admitted.

Although we could not determine where the specific breakdown occurred for each case that was not billed, we did find that the centers could use their existing computer data more effectively to identify care that should be billed. For example, at the Seattle Medical Center, from computer information, the billing clerk periodically obtained a list of care provided to veterans that the center had identified as insured. Even though, the clerk said, this allowed her to identify care that should be billed, not all care was billed because she did not have enough time to keep up with the billing workload.

Medical centers could use such lists, not only to facilitate billing, but also as an internal control to help ensure that all care was billed. When we

used similar lists to review records for a random sample of insured veterans, we found that significant amounts of inpatient care had not been billed.

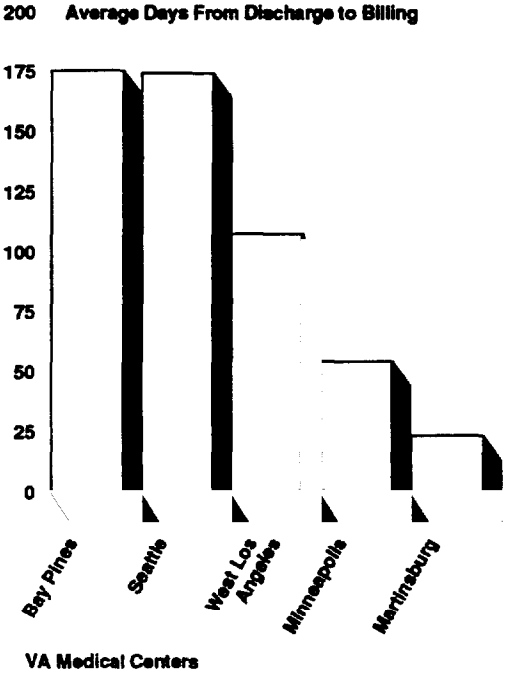
Bills Not Sent Promptly

The Federal Claims Collection Act and implementing regulations require that agency collection efforts be prompt and aggressive. Centers should bill insurers, VA's manual states, at the end of the first month when medical care was provided, which would be, at most, 30 days after the care was provided. Guidelines from the Healthcare Financial Management Association, which publishes bench marks for prompt billing and disseminates the data to hospitals nationwide, suggest billing within 7 days after providing care.

Of the five centers we reviewed, only one billed insurers for veterans in our sample within 30 days, on average, of providing inpatient care.[2] The other centers took an average of 54 to 175 days after the veteran's discharge date to prepare and send bills to insurers. (See fig. 4.2.) Three of the centers—Bay Pines, Seattle, and West Los Angeles—did not send any of the bills within 30 days of discharge for the veterans we sampled who received inpatient care.

[2]The number of bills in our sample ranged from 12 bills sent by the West Los Angeles Medical Center to 53 sent by the Martinsburg Medical Center.

Figure 4.2: Average Time Taken to Prepare Bills (Oct. 1987-Mar. 1988)



When billing is not prompt, the government loses the use of the money during the time it is owed.[3] To estimate the loss to the government due to delayed billing, we used the January 1988 U.S. Treasury Bill interest rate of 6.74 percent. We calculated the interest lost from 30 days after the date of discharge to the date the bill was sent. On the basis of this standard, we estimate that the four centers that billed, on average, more than 30 days after the veterans were discharged lost about $38,000 for fiscal year 1988 inpatient collections.[4] In other words, we estimate that the government lost almost $31 per episode of inpatient care billed at these centers.[5]

According to center officials, one problem contributing to the delays in bill preparation was the completion of the medical discharge summary, which billing staff use to prepare the insurance bill. VA's manual

[3]Collections may also be reduced because an insurer sometimes refuses to pay the amount owed if the time between the date of care and the date the insurer receives the bill exceeds the insurer's acceptable time frame. This problem is discussed in more detail in chapter 6.

[4]There is a 95-percent chance that the true value of the population lies between $19,000 and $58,000.

[5]There is a 95-percent chance that the true value of the population lies between $15 and $46.

requires billing staff to include a copy of the discharge summary with bills to insurers. A discharge summary, prepared by a physician, records the patient's medical condition, admission and discharge dates, and types of treatment provided. VA criteria state that these summaries should be completed within 6 working days after the patient's discharge. But at five of the centers we visited, medical administration service staff sometimes had to wait from several weeks to several months, they said, for the summaries to be completed.

At the Martinsburg Medical Center, which had the lowest average number of days between veterans' discharges and preparing the bills, officials were able to minimize the number of days needed to prepare the bills, they said, by

- notifying staff in departments, such as ward administration and transcription, which patients have insurance so that the paperwork for these veterans can be expedited and
- emphasizing the importance of billing insurers, setting an informal goal of 10 days from the discharge date to the date the bill is sent.

VA Can Substantially Increase Recoveries of Outpatient Care Costs

VA headquarters did not direct medical centers to bill insurers for outpatient care during fiscal year 1988. In the absence of such direction, most centers reported that in fiscal year 1988, they limited the extent of their outpatient billing or did not bill insurers for outpatient care at all. We estimate that the six centers we visited did not bill insurers for about $1.6 million of outpatient care provided during the first half of fiscal year 1988.

Billing for Outpatient Care Optional

The Veterans' Health-Care Amendments of 1986, 38 U.S.C. 629(a)(1), established the right of the United States to recover health care costs provided to certain insured veterans. Although headquarters directed medical centers to bill insurers for inpatient care, each medical center was permitted to decide whether to bill insurers for outpatient care.

Of the six centers we reviewed, three did not bill insurers for any outpatient visits and three billed insurers for some of the outpatient care provided.[1] The Martinsburg Medical Center billed insurers for some outpatient care on a limited test basis, according to the chief of the medical administration service at the center. We found that Martinsburg billed insurers for 2 percent of outpatient costs for insured veterans in our sample.[2] The center has now established procedures, the chief of insurance billing told us, to bill insurers for all outpatient care.

The Albany Medical Center billed insurers for outpatient care, according to the billing staff, when (1) the veteran had received inpatient care, (2) the veteran came to the center for outpatient care without an appointment, or (3) the veteran's income exceeded an income threshold and the veteran agreed to make a payment to VA for such care. We found that Albany billed insurers for about 22 percent of the outpatient care provided to insured veterans in our sample.[3]

The Seattle Medical Center had procedures to bill for all outpatient care, but the center's billing clerk did not, she said, have time to bill every case. Hence, she gave first priority to billing outpatient care provided to

[1] VA defines an outpatient visit as all diagnostic and therapeutic services provided to a veteran during a single 24-hour period. The appearance of a veteran at the facility solely for a prescription refill is not a visit. In fiscal year 1988, VA charged insurers $127 per outpatient visit.

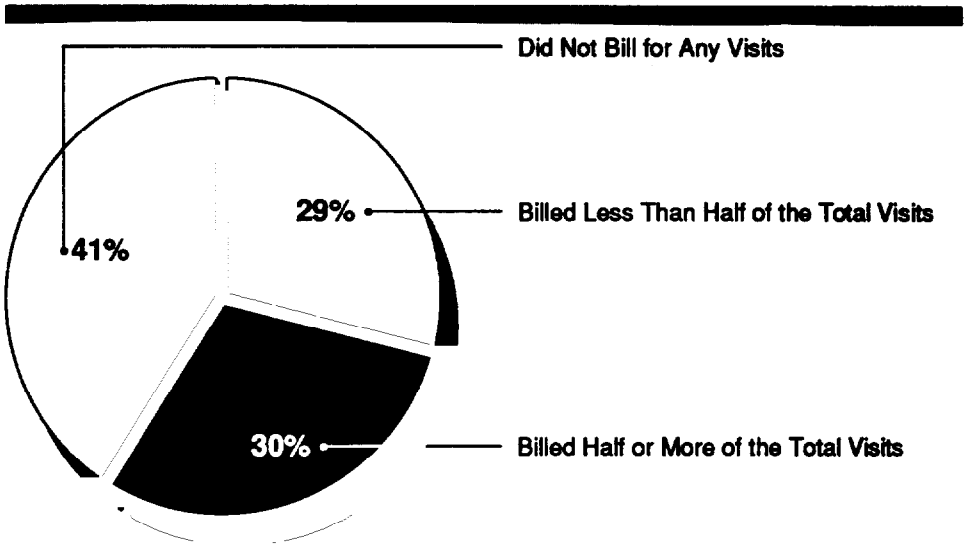
[2] There is a 95-percent chance that the true value for the Martinsburg population lies between 0 and 5 percent.

[3] There is a 95-percent chance that the true value for the Albany population lies between 7 and 40 percent.

insured veterans under the age of 65, which she believed had higher collection potential.[4] We found that Seattle billed insurers for 34 percent of the outpatient costs provided to insured veterans in our sample.[5]

In response to our questionnaire, most medical centers said they billed only for a limited amount of outpatient care or did not bill for any outpatient care during fiscal year 1988. For example, 29 centers said they limited outpatient billing to veterans who had also received inpatient care that had been billed to their insurers. The centers' responses concerning the extent to which they billed for outpatient care in fiscal year 1988 are summarized in figure 5.1.

Figure 5.1: Percentage of Medical Centers That Billed for Outpatient Care
(Fiscal Year 1988)



Note: The total number of medical centers is 159.

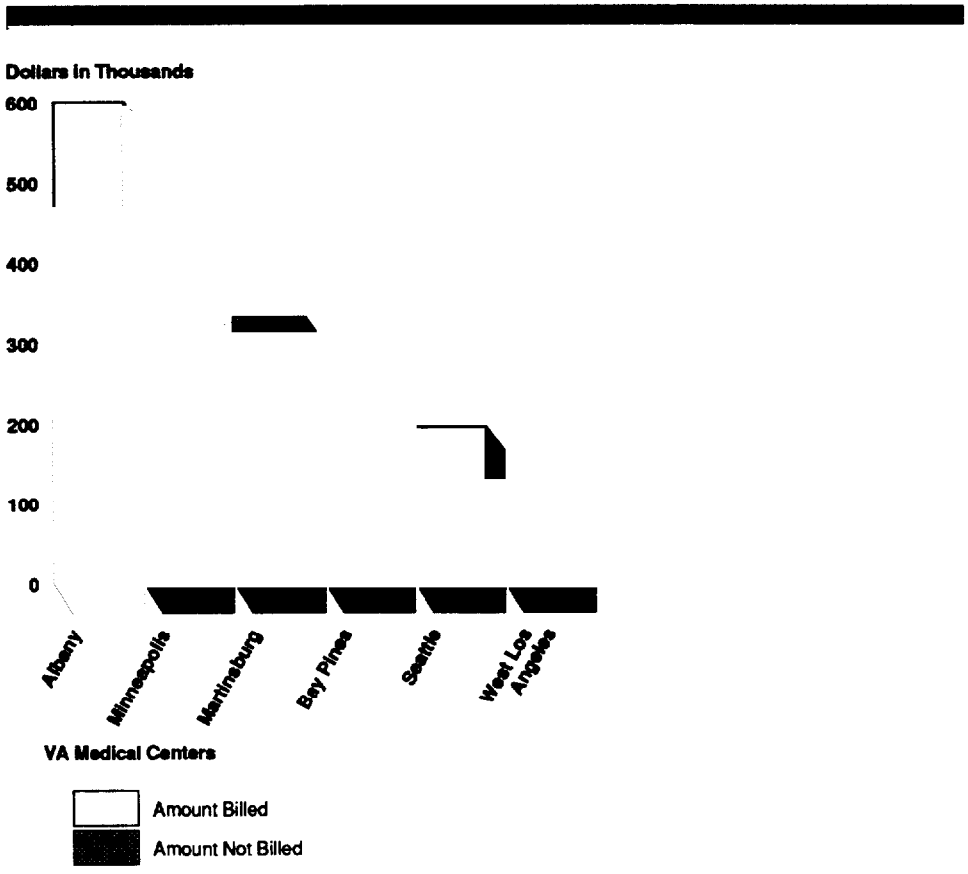
[4]A veteran under the age of 65, unless disabled, would not have both Medicare and private health insurance. As discussed in chapter 6, medical centers have experienced problems collecting from some insurers when the veterans were also covered by Medicare.

[5]There is a 95-percent chance that the true value for the Seattle population lies between 13 and 63 percent.

Opportunities Exist for Substantial Collections

We project that the six centers could have billed almost $1.8 million for outpatient care instead of the $200,000 that was billed during the first half of fiscal year 1988 (see app. VI for more detailed information about our methodology and projections).[6] Our projected outpatient care costs provided to insured veterans and the projected amounts not billed at each center are shown in figure 5.2.

Figure 5.2: Projected Value of Outpatient Care Provided to Insured Veterans
(Oct. 1987-Mar. 1988)



It is difficult to estimate the amounts that the six centers could expect to collect from the insurers for this care because of the centers' limited collection experience. Centers would not collect the entire amount billed because of insurance deductibles and coinsurance amounts. If the six centers had billed for all outpatient care and were able to collect at the same rate as the Albany Medical Center did for our sample of veterans

[6]There is a 95-percent chance that the true value for the population lies between $1.1 and $2.0 million.

(37 percent), these centers could collect over $575,000 of the projected amount not billed during a 6-month period. If the six centers experienced the same collection rate as the Seattle Medical Center did for our sample of veterans (60 percent), these centers could collect almost $934,000 of the projected amount not billed. Appendix VI contains information on the amounts collected at the three centers that billed insurers for outpatient care.

Nationwide, we estimate medical centers could have collected another $26 million to $60 million from insurers for outpatient care in fiscal year 1988 (see ch. 2).

Existing Procedures Hamper Outpatient Billing

The three centers we visited that were billing for outpatient care relied on labor-intensive procedures to verify and document care provided. Basically, billing personnel at these centers were reviewing each insured veteran's medical records to (1) verify the date(s) of care, since personnel had no other means to assure that veterans actually received care for which they were scheduled, and (2) document for the insurer the type(s) of services provided, as shown on the medical notes written by health care providers. Detailed chart reviews are time-consuming, said center personnel who did them, and ultimately limit the amount of outpatient care center personnel can bill.

The elimination of labor-intensive chart reviews would give center personnel more time to bill outpatient care. The private sector uses a preprinted treatment form that documents the date of care, diagnoses, tests, and treatments performed by the health care provider. If VA used such treatment forms in outpatient clinics to document the care provided to insured veterans, it could eliminate the time-consuming chart reviews it now uses. At the conclusion of the insured veteran's clinic visit, the health care professional would check the appropriate boxes on the form. Ultimately, clinic staff would return the form to the billing staff, who could use it to bill the insurer. The use of this form would not add significantly to the clinics' workload because it (1) includes a simple check-the-box approach and (2) would only need to be completed for insured veterans. The chief of the medical administration service at the Martinsburg Medical Center thought that implementing this step would streamline the outpatient billing process.

To make it easier for centers to bill outpatient care provided to insured veterans, VA headquarters officials are spearheading another effort—

developing an automated billing system—which it hopes will allow centers to handle a larger volume of bills. When the automated billing system becomes operational, said the former chief of the policies and procedures division in headquarters, headquarters will expect medical centers to bill for all outpatient care. The first phase of the system, installed in October 1988, allows billing clerks to use some data already in the computer, such as the insurer's address, to prepare a bill. The clerk must manually enter information on the dates and costs of inpatient or outpatient care. The accounts receivable system will help staff track bills and generate follow-up letters for overdue bills. We question whether the automated system will significantly reduce the staff time needed to prepare outpatient bills because the billing staff will continue its labor-intensive procedures to verify and document the care provided.

Medical Centers Did Not Collect All Amounts Billed to Insurers

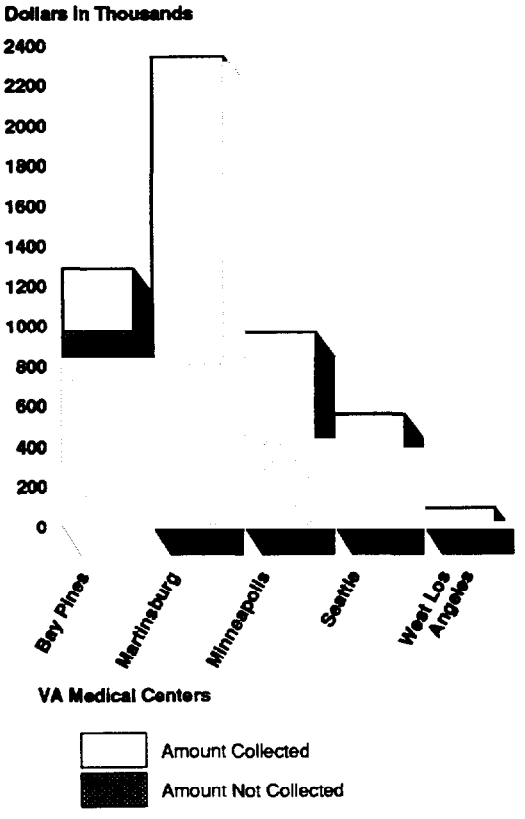
In part because of insurance policy limitations applicable to all providers, the centers did not always collect the full amounts billed. However, we found a small percentage of cases in which centers did not collect as much as they should have because they did not meet specific policy provisions, for example, submitting bills promptly. In addition, some insurers denied payment for veterans covered by both Medicare and private health insurance because Medicare was not billed first. VA plans to litigate cases denied by these insurers to clarify VA's legal authority to recover the cost of care in such instances.

Medical Center Collection Rates Vary Widely

At the five centers we visited, the collection rates varied widely for our samples of veterans. The rates for inpatient care ranged from 25 percent to 87 percent for the veterans who received inpatient care between October 1987 and March 1988.[1] These rates may be somewhat conservative because centers had outstanding bills that they were still trying to collect when our field work was completed. For example, some centers had referred uncollected bills to their district counsels' offices. If the centers ultimately collect some or all of the amounts owed on outstanding bills, the collection rates would increase. The projected amounts billed and collected for inpatient care at the five centers are shown in figure 6.1.

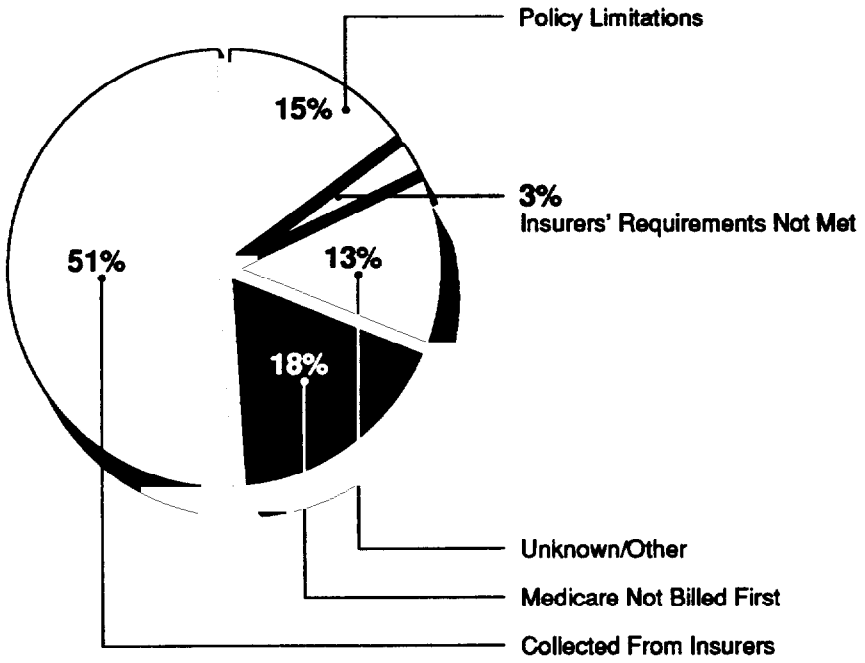
[1]Appendix V contains more detailed information about the collections per veteran and collection rates.

Figure 6.1: Projected Value of Inpatient Care Billed (Oct. 1987-Mar. 1988)



To determine the reasons that the centers did not collect the full amounts billed, we reviewed the inpatient amounts billed and collected for our sample of veterans. The proportions collected and the primary reasons for reductions in payment at the centers we visited are shown in figure 6.2.

Figure 6.2: Projected Value of Inpatient Care Billed at Five Centers—Proportions Collected and Not Collected (Oct. 1987-Mar. 1988)



For about 13 percent of the amounts billed, we were not able to determine the reasons for the reductions in payment. This is because (1) the insurers' responses did not always state the reasons for less than full payment, (2) VA could not readily provide the insurers' explanations of the amounts paid, or (3) the insurers had not yet responded. For cases in which we did not have an explanation for the payments from insurers and the centers collected at least 70 percent of the amounts billed, we assumed the unpaid portions were for policy limitations related to deductibles and coinsurance. More information about figure 6.2 is given in appendix VII.

We also reviewed the projected amounts billed and collected to determine if there were differences between the centers that would explain the differing collection rates. At the Martinsburg Medical Center, we found that insurance policy limitations accounted for the majority of the amounts not collected. In contrast, the Bay Pines Medical Center had large projected amounts denied because Medicare was not billed first. The reasons for reductions in payments are discussed in the following sections.

Many Reductions in Payments Due to Policy Limitations

The Veterans' Health-Care Amendments of 1986 established the right of the United States to recover payments from insurers for health services provided to veterans to the same extent as insurers paid to non-VA health care providers. VA would not collect the entire amount billed if a veteran's insurance policy contained (1) restrictions on the types of services covered or amounts the insurer will pay or (2) requirements that the beneficiary pay a deductible or coinsurance.

The five centers we visited did not collect an estimated 15 percent of the amounts billed because of policy limitations, and many other medical centers reported in our questionnaire that insurers paid less than the billed amounts for the same reason (see app. VIII). The three most frequently cited reasons insurers gave, as reported by centers in our questionnaire, are these:

- Eighty-three centers reported that insurers often paid only a portion of the amount billed because the insurer offset a portion of the charges against the veteran's insurance deductible or coinsurance or both. Forty centers reported that they often received no payment for this reason.
- Forty-eight centers reported that insurers often paid only a portion of the amount billed because a portion of the charges for services provided exceeded the limitations of the insurance policy.
- Thirty-seven centers reported that insurers often paid only a portion of the amounts billed because the policy did not cover some of the services provided. Twenty-eight centers reported that they often received no payment because the policy did not cover the services provided. Seventy-six others reported that this sometimes occurred.

These reasons do not indicate that VA was treated differently from other medical care providers. These providers, however, can bill some beneficiaries for any difference between the amounts billed and the insurance payments, but the amendments do not authorize VA to bill the veteran for this difference. Further, the amendments prohibit VA from collecting deductible or coinsurance amounts under health plan contracts between veterans and insurers. In these cases, VA cannot expect to collect the full amounts billed.

Collections Reduced Because Insurers' Requirements Not Met

Some insurance policies require that the medical care provider take certain steps in order to collect the maximum amounts allowed under the policies. We found that insurers sometimes paid only portions of the amounts owed because VA did not comply with all of the insurers' requirements.

Some insurers require that within 24 hours of a veteran's admission or on the next working day after admission, the centers notify the insurers of, and obtain authorization for, admissions. If centers do not obtain such authorization, they may collect only a portion or none of the billed amounts.

A VA circular issued in September 1986 required the medical centers to establish procedures for complying with insurers preadmission certification requirements. Although the centers we visited had established procedures, we found that the centers did not always obtain the needed certifications from insurers, but in only a few instances had bills for veterans in our sample been specifically denied for this reason. A district counsel legal technician for one center, however, showed that the amounts denied by insurers can be large. She cited a case, not in our sample, of a $41,591 bill that was written off because the center did not obtain authorization, even though the center had knowledge of the insurer's authorization requirement.

Twenty-three of the medical centers reported, in response to our questionnaire, that insurers often paid only a portion of the amounts billed because the centers did not obtain preadmission authorization from the insurers. Sixty other centers reported that this sometimes occurred. We also found that some collections were reduced because VA did not submit bills to insurers within insurance policy time frames. For example, the Seattle Medical Center failed to collect any of a $26,539 bill for a veteran in our sample. The insurer refused to pay because it received the bill more than 6 months after the last day of care. In responding to our questionnaire, 23 centers said they were sometimes denied payment because the insurers did not receive bills within insurers' required time frames.

Some Insurers Deny Payment Because Medicare Not Billed First

Many veterans are covered by both Medicare and private health insurance. Although some of the insurers have paid VA for care provided to these veterans, others have denied payment because Medicare was not billed first. We estimate, on the basis of our review of a sample of inpatient veteran records at five centers, that about 18 percent of the care billed to insurers was denied because Medicare was not billed first. This was also the most frequent reason for denial of payment that centers reported in our questionnaire. One hundred centers reported that insurers often refused to pay any of the amounts billed because Medicare was not billed first. Twenty-six other centers reported that this reason was given sometimes.

Many Veterans Eligible for Medicare Coverage

Many veterans treated in VA medical centers are eligible for Medicare, a federal health insurance program for people aged 65 and older and some categories of disabled people. Medicare, which is administered by the Health Care Financing Administration (HCFA), is composed of two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physicians, clinical laboratory, x-ray, and physical therapy services. Both parts require beneficiaries to share in the cost of their care through deductibles and coinsurance.

Many Veterans With Medicare Also Have Private Health Insurance

Many Medicare beneficiaries, including veterans, have private insurance to cover some or all of their medical costs not paid by Medicare. This insurance can be group insurance sponsored by former employers or individual policies purchased by beneficiaries. The National Center for Health Services Research and Health Care Technology Assessment Survey found that in 1987, almost 45 percent of the Medicare population aged 65 to 69 had private health insurance that was employment-related; almost 33 percent had other private health insurance.

Assuming no special limitations in a veteran's policy, it appears that VA has the legal authority to recover the cost of care from insurance designed to supplement Medicare. Section 629(a), title 38, authorizes VA, in specified circumstances, to recover the reasonable costs of care under veterans' health-plan contracts. Subsection (i)(1) defines a "health-plan contract" as "an insurance policy . . . or similar arrangement under which health services for individuals are provided or the expenses of such services are paid." The definition provides no exclusions that could be relevant to a Medicare supplemental policy. The Senate Budget Committee intended, it stated, that the definition ". . . be construed broadly so as to achieve broad coverage under this section with respect to the types of health plans under which recoveries and collections may be sought." Consequently, a private insurance policy supplementing Medicare benefits appears to fall within this definition. General counsel officials in VA and HCFA also believe, they stated, that VA has the legal authority to recover health care costs from these policies.

VA's Actions to Resolve Collection Problem

VA requested assistance from HCFA in 1988 to resolve the problem of collecting from insurers that denied payment because Medicare had not been billed first. Specifically, VA asked HCFA to provide either (1) an explanation of Medicare benefits for the services provided by VA when

the insurer requires such a statement or (2) a general statement, in a form that VA could share with insurers, about Medicare payments for VA-provided services.

In July 1988, HCFA responded in writing that complying with the first option would not be possible. In addition to being administratively impractical and costly, HCFA stated that it understood that 38 U.S.C. 629(i)(1)(B) precludes VA from billing Medicare, a prerequisite to issuing an explanation of Medicare benefits. However, HCFA did comply with the second option, issuing a general statement in a letter, as follows:

"Because the Medicare law prohibits payment for services provided in a VA facility, the Medicare payment for any such services would always be zero, except under the limited circumstances . . . . regarding services provided to Medicare beneficiaries not eligible for VA benefits . . . . Thus, even if VA were authorized to bill Medicare the EOMB [explanation of Medicare benefits] would state that the Medicare payment is zero."

In September 1988, VA instructed each medical center as follows: when veterans had Medicare, the center should include, with bills sent to insurers, copies of HCFA's letter.

The inclusion of HCFA's letter has not completely overcome the collection problem. For example, in a request for advice from its district counsel, the Albany Medical Center reported that the insurers were continuing to reject the bills in spite of the HCFA denial letter. At 10 of 15 other centers we contacted, staff that used the letter reported that including it with the bills sent to the insurers had not resolved the collection problems.

Since the HCFA letter has not resolved the collection problems with some insurers, VA plans to litigate cases to clarify its right to reimbursement. VA referred two cases, the VA deputy assistant general counsel said, concerning one insurer to the Department of Justice. This insurer denied payment for care in a VA medical center because the medical center did not bill Medicare first. VA subsequently advised us that the cases have been resolved and the insurer is now honoring VA's claims. In addition, VA advised us, several claims against other insurers' Medicare supplemental policies have been referred to the Department of Justice for litigation.[1]

[1]Presumably such collection problems will tend to decrease as a result of the passage of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), which, effective December 19, 1989, explicitly establishes Medicare as a secondary payer on all claims for beneficiaries also covered by an employer health plan. This law undercuts the basic argument used by many insurers who reject bills for Medicare-eligible beneficiaries.

Stronger Management Actions Needed to Maximize Insurance Collections

Managers at VA headquarters must make a commitment to (1) establishing effective recovery procedures and (2) assuring that centers have adequate resources to carry out their recovery efforts. Inadequate guidance hindered the ability of medical centers to establish effective procedures; inadequate resources caused centers not to bill insurers for all outpatient care.

VA Headquarters Guidance Inadequate

VA did not provide specific guidance concerning recovery procedures. The chief medical director gave medical centers general guidance on the recovery effort along with some basic forms to use, but delegated responsibility for establishing recovery procedures to the centers. Consequently, each center established its own procedures for identifying veterans with insurance, billing insurers, and collecting amounts owed. In response to our questionnaire, about one-third of the centers said that guidance from headquarters was inadequate. As a result, centers missed opportunities to collect more from insurers.

Medical Centers Did Not Commit Staff Needed

The medical centers did not commit staff needed to recover costs from health insurers. VA headquarters left staffing decisions up to the discretion of the centers. VA's fiscal year 1987 appropriation included 199 full-time equivalent positions for two recovery efforts or, on average, about 1 position for each center.[1] Information given by centers for fiscal year 1988 showed that about 370 full-time equivalent positions were working on the insurance recovery effort or, on average, about 2 full-time equivalent positions per center.[2] However, 122 of the 159 centers responded that the number of available staff was less than adequate to effectively recover costs from insurers (see app. IX).

To obtain the staffing and other resources needed to fully implement recovery from insurers, managers at five of the medical centers we visited told us that they would like to keep a portion of the insurance collections instead of transferring them to the U.S. Treasury. One center director said he would provide the resources necessary to increase billing and collections if he could get some funds to supplement his budget. Another director said that he would not devote additional staff for insurance billing purposes without receiving some benefit. He said that

[1]These positions were for VA's efforts to recover from certain veterans, who were required to make copayments toward the cost of their care, as well as from insurers.

[2]This estimate was calculated using the centers' responses to our questionnaire for the hours spent on the recovery effort during a typical week in fiscal year 1988.

he would have to absorb the staff for the insurance billing out of his current budget at a time when there were other unmet, medically related staffing needs at the center.

VA headquarters is considering contracting out its health insurance billing and collecting activities. Currently, VA says, it has limited statutory authority to pay, out of amounts collected, for the billing and collection services of a contractor. Allowing VA to do this would enable VA to use its appropriated funds to provide health care to veterans.

The Congress recently considered, but did not authorize, allowing VA to keep some of the funds collected from insurers to pay for its administrative costs. A bill (H.R. 901), passed by the House of Representatives, would require VA to develop an automated program to carry out the billing and collection of amounts owed to the United States. It would also require VA to pay for the costs of administering the automated program, including the costs of any contracts for billing and collection under this program, from the amounts received through the program. Of the amounts that remain after paying for administrative costs, the bill would require VA to transfer funds as follows: to the general fund of the Treasury, an amount equal to the Congressional Budget Office's estimate of collections that would have been made, in fiscal year 1990, without the automated program. After the administrative costs have been paid and the Treasury has received its specified amount, VA would allocate the remaining amounts to its medical care account and nursing home revolving fund. The bill would also require that VA submit a report, by January 1992, to the Senate and House Committees on Veterans' Affairs comparing the experience of carrying out the program through the use of (1) VA employees at not more than 20 medical centers with (2) contractor services at not more than 20 medical centers. However, these requirements were dropped from the bill in the Senate and not included in the version adopted by the Congress.

Conclusions

VA medical centers had the potential to collect substantially more, perhaps another $223 million, from private health insurers in fiscal year 1988. First, over 70 percent of the centers did not bill for outpatient care or billed for less than half of the outpatient care provided. Second, the centers struggled to establish efficient and effective billing and collection procedures—over 30 percent of the potentially collectible costs were not billed by the six centers we visited. Third, center directors have not committed the staffing needed to do the job right—additional

staffing is needed to handle insurance recoveries at two-thirds of the 159 medical centers, according to responses to our survey questionnaire.

VA headquarters should take a more active role helping medical centers to maximize collections from private insurers. First, it should work closely with the centers to improve their procedures, especially those used to (1) identify veterans with insurance and (2) bill insurers for all episodes of inpatient and outpatient care provided. Although some improvements should save money through greater efficiencies of operations, most will require medical centers to spend additional funds, a financial commitment that center directors appear reluctant to make.

Sufficient resources must be dedicated to VA's insurance recovery effort if collections are to be maximized. VA should act quickly because insurance policies have time limitations that could prevent VA from collecting for some care if it takes too long to bill for that care. To obtain adequate resources, VA should determine the additional resources necessary to maximize insurance collections. If these resources can not be found in its existing budget, VA should seek (1) the funds through the budget process or (2) legislative authority to pay its collection costs by using some of the funds collected from insurers.

Recommendations to the Secretary of Veterans Affairs

We recommend that the Secretary of Veterans Affairs ensure that all medical centers bill insurers for outpatient care they provide to insured veterans. In addition, we recommend that the Secretary ensure that each medical center has

- effective procedures for (1) identifying all veterans with health insurance and (2) billing insurers for all episodes of inpatient and outpatient care provided to insured veterans and
- sufficient resources to fully implement its identification, billing, and collection procedures.

Matter for Consideration by the Congress

Given the substantial benefit to the government possible through maximizing insurance collections, the Congress should ensure that VA has the resources necessary to fully implement its recovery efforts. If adequate resources are not available through the budget process, the Congress should consider amending 38 U.S.C. 629 to allow VA to keep a portion of the amounts collected from insurers to defray its administrative costs.

Agency Comments

VA commented on a draft of this report on February 26, 1990 (see app. X). The Department agreed with our recommendations and pointed out a number of actions being taken to improve the process and increase collections from health insurers. Actions the Department said were being taken include

- convening a task force for medical care cost recovery, charged with developing a strategy to improve identification, billing, and collection procedures as quickly as possible;
- developing an administrative order, which is currently being reviewed in the Department, that would require all facilities to bill for outpatient care;
- citing the insurance collection system as a material weakness in its 1989 Federal Managers' Financial Integrity Act report; and
- requesting input from field stations to ensure that debt collection procedures are effective after a new accounts receivable system is installed at all stations, which VA expects to be in 1990.

VA also recognized that additional resources are necessary to properly carry out the billing and collection procedures; it presented such a proposal, it said, as part of its fiscal year 1991 budget request.

After receiving VA's comments, we reviewed VA's fiscal year 1991 budget justification. It shows that this proposal would include establishing a third-party medical recovery account to bill and collect from third-parties. The fund would consist of (1) $18.6 million and 500 full-time equivalent staff transferred from the medical care account and (2) the appropriation of an additional $6.4 million and 300 full-time equivalent staff. All collections would be deposited into this account; amounts in excess of the billing and collection costs would be forwarded to the U.S. Treasury. VA estimates that this proposal will result in a $359 million increase in net receipts for Treasury in fiscal year 1991.

VA's Daily Rates Used to Prepare Bills to Health Insurers

Type of care	Fiscal year 1988	1989
Outpatient care	$127	$110
Inpatient medicine:	473	483
Room, board, and nursing	266	271
Physician	91	93
Ancillary	116	119
Inpatient surgery:	611	681
Room, board, and nursing	337	375
Physician	114	128
Ancillary	160	178
Inpatient spinal cord injury:	524	539
Room, board, and nursing	308	317
Physician	62	64
Ancillary	154	158
Inpatient psychiatry:	236	232
Room, board, and nursing	168	164
Physician	32	32
Ancillary	36	36
Inpatient neurology:	393	426
Room, board, and nursing	219	237
Physician	49	53
Ancillary	125	136
Inpatient alcohol/drug:	197	213
Room, board, and nursing	119	129
Physician	37	40
Ancillary	41	44
Inpatient rehabilitation medicine:	372	374
Room, board, and nursing	215	216
Physician	44	44
Ancillary	113	114

Total Insurance Collections and Collections Per Average Daily Occupied Bed by Medical Center (Fiscal Year 1988)

Rank[a]	Medical center location		Collections	
	City	State	Total	Per average daily occupied bed
1	Martinsburg	WV	$2,978,554	$10,378
2	White River Junction	VT	890,972	7,551
3	Erie	PA	628,214	7,391
4	Salt Lake City	UT	1,756,649	7,083
5	Charleston	SC	1,480,095	6,435
6	Iowa City	IA	1,119,172	6,218
7	Saginaw	MI	595,366	6,075
8	Boise	ID	513,751	5,974
9	Columbia	MO	1,069,550	5,243
10	Dublin	GA	1,161,128	5,027
11	Fargo	ND	580,724	4,921
12	Wichita	KS	528,621	4,895
13	Sioux Falls	SD	753,524	4,739
14	Marion	IL	590,983	4,728
15	Madison	WI	949,159	4,722
16	Fayetteville	NC	1,108,635	4,718
17	Kerrville	TX	866,860	4,636
18	Durham	NC	1,317,622	4,544
19	San Antonio	TX	1,976,689	4,288
20	Lincoln	NE	472,854	4,185
21	Omaha	NE	980,859	4,156
22	Fayetteville	AR	441,298	4,086
23	Poplar Bluff	MO	469,582	4,083
24	Altoona	PA	332,684	4,057
25	Grand Island	NE	297,626	3,865
26	Alexandria	LA	595,916	3,845
27	Columbia	SC	1,221,791	3,842
28	Richmond	VA	1,868,382	3,790
29	Wilmington	DE	567,348	3,782
30	Amarillo	TX	352,057	3,745
31	Cheyenne	WY	209,200	3,670
32	Albany	NY	1,304,243	3,603
33	Gainesville	FL	1,233,373	3,554
34	Manchester	NH	337,200	3,476
35	Louisville	KY	856,932	3,469
36	Prescott	AZ	354,452	3,408

(continued)

Rank[a]	Medical center location		Collections	
	City	State	Total	Per average daily occupied bed
37	Nashville	TN	$928,521	$3,389
38	Des Moines	IA	393,678	3,365
39	Shreveport	LA	748,864	3,358
40	Minneapolis	MN	1,622,489	3,352
41	Fort Wayne	IN	339,812	3,331
42	West Haven	CT	1,000,300	3,323
43	Washington	DC	1,359,846	3,269
44	Indianapolis	IN	984,406	3,249
45	Wood	WI	1,292,654	3,208
46	Lake City	FL	808,704	3,196
47	Clarksburg	WV	394,615	3,157
48	Mountain Home	TN	1,062,136	3,152
49	Butler	PA	588,898	3,116
50	Roseburg	OR	577,472	3,088
51	Providence	RI	588,087	3,063
52	Fort Howard	MD	517,710	3,045
53	Iron Mountain	MI	291,622	3,038
54	Leavenworth	KS	803,018	3,019
55	Walla Walla	WA	243,352	2,932
56	Bonham	TX	175,540	2,926
57	Oklahoma City	OK	776,262	2,897
58	Pittsburgh/ Univ. Dr	PA	1,153,162	2,883
59	Denver	CO	670,981	2,880
60	Hampton	VA	722,011	2,735
61	Ann Arbor	MI	563,301	2,695
62	Birmingham	AL	599,682	2,642
63	East Orange	NJ	1,376,306	2,597
64	Portland	OR	950,014	2,561
65	Beckley	WV	303,308	2,549
66	Temple	TX	870,834	2,495
67	Fresno	CA	311,842	2,417
68	Livermore	CA	202,695	2,413
69	Little Rock	AR	1,804,612	2,335
70	Hines	IL	1,695,397	2,304
71	Syracuse	NY	410,472	2,255
72	Cincinnati	OH	433,648	2,179

(continued)

Rank[a]	Medical center location		Collections	
	City	State	Total	Per average daily occupied bed
73	Tucson	AZ	$394,863	$2,170
74	Memphis	TN	1,152,075	2,137
75	Seattle	WA	609,045	2,100
76	Boston	MA	717,416	2,092
77	Dallas	TX	1,016,173	2,091
78	Augusta	GA	1,611,030	2,079
79	Wilkes Barre	PA	616,485	2,062
80	Atlanta	GA	696,689	2,049
81	Miles City	MT	124,235	2,037
82	St. Cloud	MN	769,342	1,938
83	Phoenix	AZ	612,031	1,895
84	Togus	ME	543,867	1,888
85	Chicago/ West Side	IL	630,239	1,887
86	Asheville	NC	593,346	1,884
87	Albuquerque	NM	581,263	1,869
88	Marlin	TX	282,812	1,861
89	Grand Junction	CO	118,042	1,844
90	Perry Point	MD	1,096,392	1,794
91	Fort Meade	SD	462,888	1,794
92	Bath	NY	326,128	1,782
93	Chillicothe	OH	999,995	1,718
94	Spokane	WA	172,852	1,695
95	Huntington	WV	218,776	1,683
96	Pittsburgh/ Highland	PA	844,311	1,682
97	Muskogee	OK	214,464	1,663
98	Big Spring	TX	226,033	1,615
99	Hot Springs	SD	156,909	1,569
100	St. Louis	MO	889,791	1,561
101	Marion	IN	686,587	1,506
102	Jackson	MS	447,793	1,503
103	Loma Linda	CA	355,769	1,429
104	Dayton	OH	563,196	1,394
105	Knoxville	IA	474,430	1,375
106	Kansas City	MO	383,755	1,356
107	Fort Harrison	MT	142,083	1,353

(continued)

Rank[a]	Medical center location		Collections	
	City	State	Total	Per average daily occupied bed
108	San Francisco	CA	$271,662	$1,352
109	Baltimore	MD	209,511	1,343
110	Topeka	KS	691,176	1,329
111	Sheridan	WY	342,588	1,328
112	Lebanon	PA	640,721	1,321
113	Danville	IL	816,497	1,298
114	Lexington	KY	805,392	1,272
115	San Diego	CA	366,052	1,262
116	Reno	NV	143,332	1,246
117	Brockton	MA	838,269	1,231
118	Salem	VA	726,978	1,224
119	Montgomery	AL	164,365	1,209
120	Northampton	MA	481,313	1,188
121	Allen Park	MI	430,410	1,151
122	Newington	CT	131,447	1,143
123	Long Beach	CA	714,352	1,069
124	Bay Pines	FL	491,587	1,039
125	Waco	TX	618,055	1,030
126	Salisbury	NC	703,988	1,029
127	Houston	TX	716,466	1,021
128	Tampa	FL	425,383	976
129	Northport	NY	598,708	972
130	Tuscaloosa	AL	453,294	940
131	Buffalo	NY	519,709	930
132	Chicago/ Lakeside	IL	222,723	928
133	Palo Alto	CA	880,655	928
134	Murfreesboro	TN	440,202	837
135	North Chicago	IL	556,493	778
136	Tomah	WI	375,728	764
137	Batavia	NY	87,067	757
138	Biloxi	MS	421,293	738
139	Sepulveda	CA	202,665	729
140	Battle Creek	MI	411,645	644
141	Castle Point	NY	110,960	638
142	Cleveland	OH	361,979	624
143	New Orleans	LA	181,160	596

(continued)

Rank[a]	Medical center location		Collections	
	City	State	Total	Per average daily occupied bed
144	Martinez	CA	$153,107	$565
145	Miami	FL	262,597	564
146	Bronx	NY	211,983	558
147	American Lake	WA	121,636	553
148	Tuskegee	AL	323,821	546
149	Fort Lyon	CO	135,015	511
150	West Los Angeles	CA	330,448	401
151	Canandaigua	NY	239,371	401
152	Lyons	NJ	330,724	398
153	San Juan	PR	214,353	388
154	Brooklyn	NY	146,261	266
155	Philadelphia	PA	74,023	244
156	New York	NY	107,441	216
157	Bedford	MA	118,513	215
158	Coatesville	PA	146,075	209
159	Montrose	NY	84,414	117

[a]In order of collections per bed.

When Medical Centers Began Billing Insurers

In our questionnaire, we asked centers when they began routinely billing insurers for inpatient and outpatient care. Responses are summarized in table III.1.

Table III.1: Center Responses

	Medical centers	
Fiscal year	**Outpatient**	**Inpatient**
1986 or earlier (before Oct. 1986)	10	32
1987 (Oct. 1986-Sept. 1987)	29	119
1988 (Oct. 1987-Sept. 1988)	36	8
1989 (Oct. 1988-Sept. 1989)	6	0
Start date unknown	1	0
Not started as of Oct. 1988	77	0
Total	**159**	**159**

Estimating VA's Potential Collections From Insurers

We used three steps to estimate VA's potential collections from health insurers nationwide in fiscal year 1988. First, from data reported in VA's 1987 Survey of Veterans,[1] we estimated the total number of episodes of inpatient care or outpatient visits for insured veterans. Second, we estimated the total cost of this care using VA's data. Third, we reduced the total cost of care (potential collections) to allow for health insurance policy limitations. Described below is our methodology for estimating potential collections for inpatient and outpatient care.

Estimating Total Cost for Inpatient Care

To estimate the total number of episodes of inpatient care for insured veterans in fiscal year 1988, we calculated the number of VA inpatient episodes, reported in VA's 1987 Survey of Veterans, by veterans who

- were without service-connected disabilities,
- had been patients overnight in VA hospitals in the previous 12 months,
- had health insurance plans that pay the providers directly for the services, and
- were either (1) under the age of 65 or (2) the age of 65 or older and had health insurance through their employers.

On the basis of the survey responses, we estimated that nationwide, about 80,000 episodes of inpatient care were provided to these insured veterans during the 12-month period covered by the survey. At the 95-percent confidence level, we calculated the resulting sampling error was 44,000 episodes.[2]

To estimate the total number of inpatient days of care, we multiplied the number of inpatient episodes by VA's average lengths of stay for fiscal year 1988. In the survey, the 80,000 episodes of inpatient care were placed in two categories: "surgical" or "medical," with "examination/diagnostic" episodes included in the medical category. None of the insured veterans reported receiving inpatient psychiatric care. We assumed that nearly all of the insured veterans would be under the age of 65. Therefore, we used VA's average lengths of stay for veterans

[1]Department of Veterans Affairs, 1987 Survey of Veterans,IM&S-M 70-89-1 (Washington, D.C., July 1989).

[2]We calculated the sampling error at the 95-percent confidence level on the basis of a formula used by the Census Bureau for the 1987 Survey of Veterans, which it did for VA. This confidence level means that the chances are about 19 out of 20 that the actual number being estimated falls within the range defined by our estimate, 80,000 episodes, plus or minus the sampling error, 44,000 episodes.

under the age of 65,[3] which were 10.4 days for medical care episodes and 8.6 days for surgical care episodes. To estimate VA's total cost for this inpatient care, we multiplied the total number of inpatient days of care by VA's reported daily rates for fiscal year 1988. These daily rates were $611 for surgical and $473 for medical care. We estimated the total cost of inpatient care for insured veterans to be $395 million, with a sampling error of plus or minus $217 million. Since our cost estimate is based on the estimated number of episodes of care, the sampling error for the costs is proportional to the sampling error for the number of episodes of care.

Estimating Total Costs for Outpatient Care

To estimate the total number of outpatient visits for insured veterans in fiscal year 1988, we calculated the total number of outpatient visits, reported in VA's 1987 Survey of Veterans, by veterans who

- were without service-connected disabilities,
- had made visits for medical treatment to VA clinics or VA hospitals on an outpatient basis in the previous 12 months,
- had insurance plans that pay the providers directly for the services, and
- were either (1) under the age of 65 or (2) the age of 65 or older and had health insurance through their employers.

On the basis of the survey responses, we estimated that nationwide, 180,000 insured veterans made one or more outpatient visits to VA health care facilities during the 12-month period covered by the survey. The survey asked veterans to estimate the number of VA outpatient visits they had made during the preceding 12 months, that is, 1 visit, 2 to 5 visits, 6 to 10 visits, 11 or more visits. To estimate the number of visits nationwide, we used the lower value of each range. This resulted in an estimate of 850,000 visits.

To allow for insurance deductibles, we assumed the first 2 visits by a veteran would be used to meet the insurance deductible. Thus, we subtracted 37,000 visits from the total estimated visits to adjust for veterans who reported only 1 visit; we subtracted 284,000 visits for veterans who reported 2 or more outpatient visits. This left an estimated total of 529,000 outpatient visits for which recovery from insurers seemed possible.

[3]We used VA's reported average lengths of stay for short-term discharges, which are defined as stays of 99 days or less.

To estimate VA's total cost for these outpatient visits, we multiplied the number of outpatient visits by VA's reported daily rate for fiscal year 1988, which was $127. Thus, we estimate the total cost of 529,000 outpatient visits to be $67 million. At the 95-percent confidence level, this estimate has a sampling error of plus or minus $24 million.

Estimating Potential Collections From Insurers

We recognized that many health insurance policies have provisions for deductibles and copayments. To allow for insurance deductibles and copayments for inpatient care, we reduced the estimated total costs by 30 percent. Thus, we assumed, on average, insurers would be liable for 70 percent of the total VA cost of providing inpatient health care. For outpatient care, as discussed above, we allowed for deductibles by reducing the number of outpatient visits. We allowed for outpatient care coinsurance by reducing the total costs for the remaining visits by 30 percent. At the 95-percent confidence level, we estimate potential collections of $125 to $428 million from insurers for inpatient care in fiscal year 1988. For outpatient care, we estimate potential collections of $30 to $64 million.

Methodology and Results for Our Review of Samples of Insured Veterans Receiving Inpatient Care

At the five medical centers whose inpatient records we reviewed, we asked center officials to give us a list of the veterans without service-connected disabilities who were (1) identified as insured and (2) discharged from inpatient care between October 1, 1987, and March 31, 1988. From this list we randomly selected a sample of approximately 30 veterans at each medical center.

We did not include a veteran in our samples if

- we could not find sufficient evidence that the veteran was actually covered by insurance during the 6-month period of our review,
- the veteran had Health Maintenance Organization (HMO) coverage or was covered by an indemnity policy,
- the veteran's records indicated he or she had a service-connected disability, or
- we could not verify that the veteran received inpatient care during the period reviewed.

For each veteran sampled, we reviewed the veteran's administrative and medical records to determine (1) the value of care provided, (2) the amount of care that could have been billed but was not, (3) the amount of care that was billed to insurers, and (4) the amount that was collected.

For each center visited, we projected our findings to the universe of insured veterans without service-connected disabilities who were discharged between October 1, 1987, and March 31, 1988. We also projected the associated precision of our estimates for the 95-percent confidence level. The projected amounts that could have been billed to insurers but were not are summarized in table V.1.

Table V.1: Projected Value of Inpatient Care Provided to Insured Veterans, October 1, 1987, Through March 31, 1988, and Not Billed to Insurers

Medical center	Average amount not billed per veteran	Range for 95-percent confidence level		Projected to medical center population		
		Low	High	Estimated value of care not billed	Range for 95-percent confidence level Low	High
Bay Pines	$3,746	$2,051	$5,441	$782,837	$428,660	$1,137,014
Martinsburg	74	12	207	14,560	2,365	40,676
Minneapolis	1,617	219	3,015	252,317	58,227	470,447
Seattle	1,910	317	3,503	227,262	57,293	416,784
West Los Angeles	9,305	3,474	15,136	502,472	297,761	817,350
Total	**$2,421**	**$1,665[a]**	**$3,177[a]**	**$1,779,448**	**$1,223,776[a]**	**$2,335,120[a]**

These figures are the range for our projections, not the average or sum of the values listed for the individual medical centers.

We also reviewed the records for the veterans sampled to determine the amounts that the centers billed to insurers and the amounts recovered. The amounts of care the centers billed to insurers are summarized in table V.2.

Table V.2: Projected Value of Inpatient Care Provided to Insured Veterans, October 1, 1987, Through March 31, 1988, and Billed to Insurers

Medical center	Average amount billed per veteran	Range for 95-percent confidence level		Projected to medical center population		
		Low	high	Estimated value of care billed	Range for 95-percent confidence level Low	High
Bay Pines	$6,143	$1,494	$10,793	$1,283,943	$312,215	$2,255,671
Martinsburg	8,643	4,862	12,424	2,333,590	1,312,808	3,354,372
Minneapolis	6,136	3,885	8,357	957,203	606,045	1,308,361
Seattle	4,659	2,551	6,767	554,425	303,524	805,326
West Los Angeles	1,617	958	2,356	87,291	51,728	136,953
Total	**$6,456**	**$4,631[a]**	**$8,281[a]**	**$5,216,452**	**$3,741,671[a]**	**$6,691,233[a]**

[a]These figures are the range for our projections, not the average or sum of the values listed for the individual medical centers.

In many cases, we were unable to determine the amount that VA could expect to collect from insurers for the care provided; this is because the medical and administrative records we reviewed did not contain adequate information on the veterans' insurance coverage. The collection rates shown in table V.3 were calculated by dividing the average amount collected per veteran by the average amount billed per veteran.

For various reasons, centers had not closed all cases for sampled veterans at the time or our review. For example, the Seattle Medical Center had referred some cases to the VA district counsel for assistance. We assumed that the centers would not collect any additional funds from open cases. If the centers did collect more money, the collection rates would increase.

Table V.3: Centers' Projected Collection Rates for Inpatient Care Provided, October 1, 1987, Through March 31, 1988, and Billed to Insurers

				Projected to medical center population		
	Average amount collected per	Range for 95-percent confidence level			Range for 95-percent confidence level	
Medical center	veteran	Low	high	Estimated collection rate (percent)	Low[a]	High[b]
Bay Pines	$1,513	$217	$3,356	25	4	55
Martinsburg	5,758	2,991	8,525	67	35	99
Minneapolis	3,376	2,043	4,709	55	33	77
Seattle	1,455	556	2,354	31	12	51
West Los Angeles	1,414	838	2,321	87	52	100
Total	**$3,276**	**$2,195**	**$4,358**			

[a]This was calculated by dividing the projected amount collected per veteran at the low end of the range by the projected average amount per veteran.

[b]This was calculated by dividing the projected amount collected per veteran at the high end of the range by the projected average amount per veteran.

Methodology and Results for Our Review of Samples of Insured Veterans Receiving Outpatient Care

At the six medical centers whose outpatient records we reviewed, we asked center officials to give us a list of the veterans without service-connected disabilities who (1) were identified as insured and (2) received outpatient care between October 1, 1987, and March 31, 1988. From this list, we randomly selected a sample of approximately 30 veterans at each medical center.

We did not include a veteran in our samples if

- we could not find sufficient evidence that the veteran was actually covered by insurance during the 6-month period of our review,
- the veteran had Health Maintenance Organization (HMO) coverage or was covered by an indemnity policy,
- the veteran's records indicated he or she had a service-connected disability, or
- we could not verify that the veteran received outpatient care during the period reviewed.

For each veteran sampled, we reviewed the veteran's administrative and medical records to determine (1) the value of care provided, (2) the amount of care that could have been billed but was not, (3) the amount of care that was billed to insurers, and (4) the amount that was collected.

We projected our findings to the universes of insured veterans without service-connected disabilities who received outpatient care between October 1, 1987, and March 31, 1988, at the centers visited. We also projected the associated precision of our estimates for the 95-percent confidence level. The projected amounts that could have been billed to insurers but were not are summarized in table V1.1.

Table VI.1: Projected Value of Outpatient Care Provided to Insured Veterans, October 1, 1987, Through March 31, 1988, and Not Billed to Insurers

Medical center	Average amount not billed per veteran	Range for 95-percent confidence level		Projected to medical center population		
		Low	high	Estimated value of care not billed	Range for 95-percent confidence level Low	High
Albany	$533	$116	$950	$468,981	$101,749	$836,213
Bay Pines	479	270	688	245,497	138,269	352,725
Martinsburg	385	293	477	325,888	248,108	403,668
Minneapolis	506	277	735	336,468	184,055	488,881
Seattle	300	179	421	128,371	76,751	179,991
West Los Angeles	504	308	700	50,901	31,084	70,718
Total	**$453**	**$330[a]**	**$576[a]**	**$1,556,106**	**$1,133,383[a]**	**$1,978,829[a]**

[a]These figures are the range for our projections, not the average or sum of the values listed for the individual medical centers.

We also reviewed the records for the veterans sampled to determine the amounts that the centers billed to insurers (see table VI.2) and the amounts recovered.

Table VI.2: Projected Value of Outpatient Care Provided to Insured Veterans, October 1, 1987, Through March 31, 1988, and Billed to Insurers

Medical center	Average amount billed per veteran	Range for 95-percent confidence level		Projected to medical center population		
		Low	high	Estimated value of care billed	Range for 95-percent confidence level Low	High
Albany	$149	$39	$260	$131,355	$34,165	$228,545
Bay Pines	0	0	0	0	0	0
Martinsburg	6	1	14	5,465	508	12,187
Minneapolis	0	0	0	0	0	0
Seattle	157	42	272	67,039	17,859	116,219
West Los Angeles	0	0	0	0	0	0
Total	**$59**	**$28[a]**	**$91[a]**	**$203,859**	**$94,727[a]**	**$312,991[a]**

[a]These figures are the range for our projections, not the average or sum of the values listed for the individual medical centers.

In many cases, we were unable to determine the amount that VA could expect to collect from insurers for the care provided; this is because the medical and administrative records we reviewed did not contain adequate information on the veterans' insurance coverage. The collection rates shown in table VI.3 were calculated by dividing the average amount collected per veteran by the average amount billed per veteran.

For various reasons, centers had not closed all cases for these veterans at the time or our review. We assumed that the centers would not collect any additional funds from open cases. If the centers did collect more, the collection rates would increase.

Table VI.3: Centers' Collection Rates for Outpatient Care Provided, October 1, 1987, Through March 31, 1988, and Billed to Insurers

				Projected to medical center population		
	Average amount collected per	Range for 95-percent confidence level		Estimated collection	Range for 95-percent confidence level	
Medical center	veteran	Low	high	rate (percent)	Low[a]	High[b]
Albany	$55	$2	$127	37	1	85
Bay Pines	0	0	0	0	0	0
Martinsburg	1	0	2	11	0	31
Minneapolis	0	0	0	0	0	0
Seattle	95	23	166	60	15	100
West Los Angeles	0	0	0	0	0	0
Total	**$26**	**$5**	**$47**			

[a]This was calculated by dividing the projected amount collected per veteran at the low end of the range by the projected average amount per veteran.

[b]This was calculated by dividing the projected amount collected per veteran at the high end of the range by the projected average amount per veteran.

Projected Value of Amounts Collected and Reasons for Less Than Full Payment for Inpatient Care Billed at Five Centers

To determine the amounts collected and the reasons for less than full collection for our five samples of insured veterans who received inpatient care (see app. V), we reviewed care that was billed to insurers. We projected these findings to the population of similar veterans at the five centers. The projected amounts and associated range for the 95-percent confidence level are summarized in table VII.1.

Table VII.1: Projected Values Billed to Insurers for Inpatient Care, October 1, 1987, Through March 31, 1988, Collected and Not Collected From Insurers

	Estimated		Range for 95-percent confidence level		
	Amount	Percent	Low	High	Percent (low-high)
Collected	$2,646,176	51	$1,787,156	$3,505,196	34–67
Not collected:					
Policy limitations	773,094	15	266,305	1,279,883	5–25
VA did not bill Medicare first	936,478	18	149,638	1,782,520	3–34
Insurers' requirements not met	154,898	3	34,125	345,885	1–7
Unknown/ other[a]	707,683	13	346,079	1,069,287	7–21

[a]These were cases (1) that were not closed at the time of our review or (2) for which the center collected less than 70 percent of the amount billed and we could not determine the reason for less than full payment.

Reasons for Denial or Partial Payment of Bills

I. Our questionnaire listed possible reasons why an insurer did not pay any of the amount billed. The centers indicated how often, during fiscal year 1988, insurers gave each of these reasons for not paying any of the amount billed:

Reason for denial	Very often	Often	Sometimes	Rarely	Never
Insurer offset the total amount charged against the veteran's insurance deductible	13	27	53	41	23
Policy does not cover any of the services provided	5	23	76	48	5
Bill was not received within the insurer's required time frame	0	2	21	48	85
VA did not bill Medicare first	61	39	26	11	18
Policy was not in effect—veteran was not insured when care was provided	8	16	80	49	4
Care billed to an HMO was neither for emergency nor preauthorized	22	18	42	41	31
Care billed to an insurer other than an HMO was not preauthorized	7	10	50	65	25
Services provided were not medically necessary	3	12	40	64	37
VA has no contract with the insurer	15	9	31	55	47
Insurer does not pay for care provided at a VA medical center	12	23	58	45	19
Charges for the services provided exceeded the limitations of the insurance policy	4	23	56	45	28
Health insurance (excluding indemnity policies) payment made directly to veteran	0	16	59	63	19

II. The questionnaire listed possible reasons why an insurer pays only a portion of the amount billed. The centers indicated how often, during fiscal year 1988, insurers gave each of these reasons for paying only a portion of the total amount billed:

Reason for partial payment	Very often	Often	Sometimes	Rarely	Never
Insurer offset a portion of the charges against the veteran's insurance deductible and/or coinsurance	36	47	55	10	9
A portion of the charges for services provided exceeded the limitations of the insurance policy	19	29	63	36	10

(continued)

Reason for partial payment	Very often	Often	Sometimes	Rarely	Never
Policy does not cover some of the services provided	8	29	88	24	8
Services billed were not preauthorized	6	17	60	58	16
Length of stay exceeded the insurer's allowable length of stay	3	9	58	61	26
Some of the services provided were not medically necessary	2	15	44	59	37
Charges were not reasonable	0	9	31	53	64

Factors Affecting Recoveries

Our questionnaire asked medical centers to consider various factors that may influence how effectively the center was able to recover health care costs from insurers. For each factor, the center indicated whether it was more than, about, or less than adequate to enable the center to effectively recover costs from insurers.

Factor	More than adequate	About adequate	Less than adequate
Number of available staff	2	35	122
Staff's skills/experience	28	102	29
Training you are able to provide staff	7	90	62
Computer hardware	7	70	80
Computer software	6	63	84
Guidance from VA headquarters	2	100	56
Veterans' cooperation with your efforts	9	104	44
Insurers' cooperation with your efforts	5	84	70
District counsel's efforts to pursue referred cases	31	87	28

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

FEB 2 6 1990

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
U. S. General Accounting Office
Washington, DC 20548

Dear Mr. Baine:

I am pleased to respond to your January 2, 1990, report VA HEALTH CARE: Better Procedures Needed To Maximize Collections From Health Insurers (GAO/HRD-90-64). Since 1986 when the Congress authorized the Department of Veterans Affairs (VA) to collect from health insurers for medical care, we have strived to fully implement this mandate. We believe the GAO report documents that the Department has made significant progress with the collection of about $100 million in Fiscal Year 1988.

We also recognize that more can be done to improve the collection process. We agree with your recommendations, and actions are already underway that should improve the process and increase collections from health insurers. The actions being taken as well as other comments on your report are outlined in the enclosure.

Thank you for the opportunity to comment on this report.

Sincerely,

Edward J. Derwinski

Enclosure
EJD/jev

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS ON THE JANUARY 2, 1990, GAO REPORT VA HEALTH CARE: BETTER PROCEDURES NEEDED TO MAXIMIZE COLLECTIONS FROM HEALTH INSURERS

GAO recommends that I require all medical centers to bill for outpatient care. In addition, GAO recommends that I ensure that each medical center has:

- **effective procedures for (1) identifying all veterans with insurance and (2) billing insurers for all inpatient and outpatient care provided to insured veterans.**

We concur with the recommendation. The Department has convened a Medical Care Cost Recovery Task Force charged with developing a strategy to improve identification, billing, and collection procedures as quickly as possible. In addition, the Veterans Health Services and Research Administration (VHS&RA) has in the concurrence process an administrative issue that requires all facilities to incorporate billing procedures for outpatient visits. VHS&RA is also establishing procedures for a billing training guide. In addition, they have planned changes to the Decentralized Hospital Computer Program system that will automate additional portions of the billing process. These changes will provide additional management reports to assist in the complete and timely capturing of billing information. Finally, the VHS&RA has scheduled a monthly national conference call for all involved services to assist with any problems they encounter.

- **Sufficient resources to fully implement its identification, billing, and collection procedures.**

We concur with the recommendation and have proposed a multifaceted plan to correct the situation. The Department has listed this finding as a material weakness in the VA's 1989 Federal Manager's Financial Integrity Act (FMFIA) Report that tasks the VHS&RA to identify deficiencies and follow through with an action plan. We anticipate that the first results of this action will be completed by March 1990.

An internal review of the third party billing and collection activity within VA was completed in September 1989. As a result, a number of recommendations were proposed and are being considered for implementation.

We plan to request input from field stations to insure that our debt collection procedures are effective at the field station level once an accounts receivable module is installed at all stations. Installation is expected this calendar year. We will enhance our accounts receivable module as permitted by our resources.

2.

We recognize that additional resources are necessary to properly perform the billing and collection efforts and have presented a proposal in the 1991 budget legislation. Moreover, if Congress can provide additional resources for this program, as suggested in the audit report, we will be able to continue to significantly improve billings and collections.

The following comments are offered to specific parts of the report:

Now on p. 40.

- At page 50 of the draft report, our referral of two cases to the Department of Justice for litigation against one insurer is discussed. This matter has since been resolved, and the insurer is now honoring VA's claims against them. Recently, however, several claims against other insurers' Medicare supplemental policies were referred to the Department of Justice for litigation.

Now on p. 42.

- On page 52, the report discusses the need for legislation to permit VA to pay contractors out of amounts collected for billing and collection activities. Currently, there is limited statutory authority to pay for collection services out of amounts collected. Authority is lacking, however, to pay a contractor out of amounts collected for services in identifying cases and preparing bills.

Now on p. 21.

- On page 26, the official name for the medical center in Bonham, Texas, is the Sam Rayburn Memorial Veterans' Center.

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