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VA HEALTH CARE

Collections Fall Short of Expectations

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VA Health Care: Collections Fall Short of Expectations

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) efforts to increase revenues from alternative sources as a way to supplement its medical care appropriations. My remarks today will focus on VA's management of its efforts to increase collections from third-party insurers, because this area represents the largest source of alternative revenue. Specifically, I will discuss trends in third-party collections and VA's efforts to increase its collections.

My testimony is based on an update of our 1997 report on VA's third-party program.[1] To update that report, we reviewed (1) reports on VA's medical care collections program by VA's Inspector General and Coopers and Lybrand and (2) VA's internal reports, including its Three Tier report, regarding implementation of medical care collections activities. We also interviewed officials at VA's Central Office and at two VA facilities—the New Jersey Health Care System (NJHCS), which includes the VA Medical Centers in East Orange and Lyons, New Jersey, and the Houston, Texas, VA Medical Center.[2] We selected NJHCS because it had the highest medical care collections from October 1998 through July 1999 and the Houston Medical Center because it had a greater workload than NJHCS but had collected considerably less money during the same period.

In summary, VA's third-party collections have declined in each of the past 3 fiscal years and may decline again by the end of fiscal year 1999. In fiscal year 1998, VA collected $442 million from third-party insurers for care provided to veterans for non-service-connected conditions, down from $523 million in fiscal year 1995. In fiscal year 1999, as of August 31, VA had collected about $388 million from third-party insurers. Unless VA's September collections exceed by $19 million its average monthly collections of $35 million, the annual decline in third-party collections will continue for the fourth year in a row. Next fiscal year, VA will experience its first full year of billing insurers on a reasonable-charges basis rather than a reasonable-cost basis. However, data are insufficient to predict whether this will reverse the declining collections trend.

VA has tried to reverse the decline in its collections from third-party insurers. Three factors limit VA's ability to increase the amount it collects

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

[2] The New Jersey Health Care System is part of Veterans Integrated Service Network (VISN) 3, based in the Bronx, New York. The Houston Medical Center is part of VISN 16, based in Jackson, Mississippi.

from private insurers—the increasing number of veterans whose primary insurance is Medicare, increasing health maintenance organization (HMO) penetration, and its own efforts to increase the emphasis on outpatient care. Nevertheless, VA can enhance its chances of increasing collections if it ensures that the management improvements that are being implemented at some facilities are implemented throughout VA. These include overall improvements in VA medical facilities' use of good business management practices, as well as specific improvements in how facilities collect insurance information, document the appropriateness and medical necessity of care being billed, and pursue unpaid bills.

Background

VA's health care system—the nation's largest direct health care provider—serves about 15 percent of the nation's 25 million veterans. VA has more than 600 delivery locations to provide services such as primary care, specialized medical care, mental health care, geriatrics care, and extended care.

In 1986, the Congress gave VA authority to bill private insurers for care provided to insured veterans who did not have service-connected disabilities. In 1990, this authority was expanded to allow VA to collect for the treatment of veterans with service-connected disabilities, if the treatment was for a non-service-connected medical condition. With the enactment of the Balanced Budget Act of 1997 (BBA), the Congress changed the third-party program into one designed to supplement VA's medical care appropriations by allowing VA to retain all third-party collections. The law established the Medical Care Collections Fund (MCCF) to receive third-party collections and some other revenues (such as veterans' copayments and deductibles). VA can use these funds to provide medical care to veterans and to pay for its medical care collection expenses. Before the MCCF was established, VA was allowed to keep enough collections to fund its collection activities but deposited the remainder in the U.S. Treasury.

BBA also gave VA authority to change its basis for billing third-party insurers from "reasonable costs" to "reasonable charges." Under reasonable costs, VA based its billing of insurers on its average cost to provide care—for example, a flat fee of $229 for veterans' outpatient visits in fiscal year 1999. For inpatient visits, VA billed insurers a per diem based on patients' locations in the hospital. For example, VA charged $2,079 per day of care in a surgical bed section in fiscal year 1999. Under reasonable charges, VA will base its bills to insurers on market prices. VA expects that

it will help increase third-party collections. However, we concluded that the effect of reasonable charges on VA's collections could not be accurately determined.[3]

In January 1997, VA proposed a 5-year plan to operate within an appropriation of $17 billion per year through fiscal year 2002. By the end of fiscal year 2002, VA planned to reduce its average health care costs per patient by 30 percent, serve 20 percent more veterans, and obtain 10 percent of its funding from "alternative revenue streams." These revenue streams were to include, in addition to third-party insurance collections, collections of veterans' copayments and deductibles, collections from the Medicare program, and proceeds from sharing agreements under which VA would sell services to other providers such as the Department of Defense and private hospitals. VA's fiscal year 2000 budget acknowledges that it will not meet the 10-percent goal, in part because the Congress has not authorized Medicare payments to VA. VA estimates that it will have obtained 4.3 percent ($772 million) of its medical care funding from "alternative" sources by the end of fiscal year 1999, increasing to 7.6 percent (about $1.4 billion) in fiscal year 2002.

Collections From Third-Party Insurers Are Declining

To help serve more veterans and enhance services, VA had planned on increasing collections from third-party insurers to supplement its medical care appropriations but has been unable to achieve projected amounts. In fact, VA's collections have decreased in each of the past 3 fiscal years and may decrease again by the end of fiscal year 1999. In our 1997 report, we identified a number of factors that limit VA's ability to collect from insurers. We believe these factors will continue to limit VA's collections potential, although quantifying the magnitude of the effect is difficult because the necessary data are not available. However, one factor that we identified—refunds of overpayments by private insurers—has not had a major effect on VA's ability to increase collections. Such refunds could affect future collections if private insurers continue to discover more instances of overpayments for care provided after July 1997 and request refunds from VA.

Third-Party Collections Continue to Decline

In fiscal year 1995, VA collected $523 million from third-party insurers. Since then, the amount collected has declined every fiscal year and may decline again in the current fiscal year. Collections declined from

[3]VA Health Care: Third-Party Charges Based on Sound Methodology; Implementation Challenges Remain (GAO/HEHS-99-124, June 11, 1999).

$523 million in fiscal year 1995 to $495 million in fiscal year 1996, $450 million in fiscal year 1997, and $442 million in fiscal year 1998. As of August 31, 1999, VA had collected $388 million during fiscal year 1999. VA's average collections are about $35 million per month, but it will have to collect $54 million in September to equal fiscal year 1998's collections.

In our 1997 report, we analyzed several factors that limit VA's potential to collect more from private insurers. First, an increasing percentage of veterans are older than 65 and eligible for Medicare, which by law does not pay for care furnished by VA. VA has estimated that in 1999, 38 percent of the veteran population is older than 65, up from 32 percent in 1994. Second, more veterans are enrolling in HMOs and other managed care plans. For example, according to data provided by VA, total HMO enrollment in the general population increased from 25.8 million in December 1986 to 58.8 million in January 1997. Because VA is not a participating provider, it typically cannot collect from such plans. Third, VA's shift in emphasis from hospital care to outpatient care has resulted in more episodes of less expensive outpatient care and fewer episodes of more expensive inpatient care. This in turn has a tendency to decrease the amount that can be billed to insurers. Between fiscal years 1995 and 1998, the annual number of VA inpatient episodes dropped from 879,000 to 617,000, while outpatient episodes rose from 26.5 million to 33.4 million.

Overpayment Refunds Are Still a Potential Problem, Although Current Collections Have Not Been Significantly Affected

In 1997, we reported that VA might have to refund as much as $600 million in overpayments to some insurers. These overpayments were made by insurers whose policies contain provisions making their coverage secondary to Medicare when policyholders become eligible for Medicare. VA's bills did not specify that these insurers were expected to pay as a secondary, rather than a primary, payer. Thus, some insurers whose policies contain such provisions have paid VA as the primary payer. Some of these insurers are seeking refunds of previous payments to VA or are reducing current payments. VA's position is that it will refund overpayments to insurers whose claims are timely and well grounded.

Based on data provided by VA's Office of General Counsel, actual refunds to insurers have been relatively small compared with potential liabilities. Specifically, at the time of our review, VA officials estimated that total repayments would probably not exceed $100 million and told us that they had repaid approximately $19 million. However, unknown refunds have been paid by individual medical facilities, and claims for about an additional $29 million are pending. For example, NJHCS recently agreed to

pay an insurer approximately $286,000 after the insurer audited NJHCS bills. At the Houston Medical Center, we found one repayment in fiscal year 1999 for about $35,000.

Most of VA's refunds have come from an account in the Treasury, not from VA's medical care funds, because most overpayments occurred before July 1997, when VA was still required to deposit excess collections in the Treasury. Of the $19 million in refunds reported by VA's Office of General Counsel, all but about $800,000 was paid from the Treasury account. Also, all but about $86,000 of the $286,000 refund by NJHCS came from the Treasury account. All the $35,000 refund by the Houston Medical Center came from its current medical care account.

To prevent this type of overpayment in the future, VA is working with the Health Care Financing Administration (HCFA) to develop a facsimile of the Medicare remittance advice that would provide information on the secondary payer's share of billed charges for VA's use in billing insurers.[4] However, according to a VA official, HCFA has delayed this because of higher-priority computer programming needs. In the interim, VA has instructed medical facilities to annotate bills, when applicable, to state that the insurer is billed as a secondary, not primary, payer. VA expects that this interim step will help ensure that insurers who should be paying VA as secondary payers are not paying as first-party payers. VA also expects that its ability to provide HCFA Medicare remittance advice documents will help overcome VA's difficulty in collecting from some Medicare supplemental insurers. These insurers refuse to pay VA because it neither bills such insurers the way HCFA does for non-VA patients nor provides them with Medicare remittance advices along with each bill. VA is currently in litigation with some Medicare supplemental insurers over this issue.

VA Has Taken Initiatives to Improve Collections, but Could Do More

VA has several initiatives under way to improve its third-party collections. These initiatives address the entire process of collecting from insurers—from the initial identification of an insured veteran through the identification of billable care to the payment by the insurer. The initiatives are intended to address problems identified in the past by VA's Inspector General, Coopers and Lybrand, and us that adversely affect collections such as ineffective management, inadequate information on veterans' insurance coverage, inaccurate billing, and inadequate follow-up of outstanding bills. The initiatives are a step in the right direction but must

[4]HCFA produces these statements, which provide an explanation of the Medicare allowable charges and the portion of the billed charges Medicare will pay. The statements are provided to insurers who pay secondary to Medicare.

be effectively implemented throughout VA to improve its potential for increasing collections from third-party insurers.

The Business Model Concept Has Not Been Fully Implemented

In its 1998 report, Coopers and Lybrand pointed out that only 25 percent of the 24 VA sites it visited incorporated the various functions of the medical care collections program under a centralized management structure—what it calls the “business model.” According to Coopers and Lybrand, this type of organization is characteristic of successful private-sector hospital operations. As of June 30, 1999, about half of VA’s facilities had implemented this concept. In our site visits, VA officials supported moving to this concept because it enables them to better control the quality of their medical documentation. For example, NJHCS is considering reorganizing under such a structure so that all coders and billers would come under the system’s Medical Administration Service instead of being in several different sections.

Better Identification and Accuracy of Veterans’ Insurance Are Needed

Having accurate information on third-party insurance, such as the type of policy and the types of services covered, patient copayments and deductibles, and preadmission certification requirements, is key to VA’s medical care collections program. Yet only 54 percent of VA facilities reported that their collection of health insurance information was thorough by June 1999. Without adequate information on veterans with insurance and the provisions of that insurance, VA could miss opportunities to bill insurers for non-service-connected care provided to veterans or inappropriately bill insurers when a veteran’s policy did not cover the care provided. Sixty-five percent of VA’s facilities reported that they periodically verified and maintained their insurance files.

Because veterans have little incentive to provide insurance information, VA is trying to educate both veterans and staff about the importance of obtaining such information.[5] Specifically, VA has brochures explaining the need for this information. In addition, some VA facilities have emphasized the need for facility staff to obtain insurance information when veterans enroll in the VA health care system. NJHCS officials stressed that their goal is to ensure that all required information—including employment and insurance information—is obtained when a veteran first comes in contact with NJHCS. This contact may occur during one of NJHCS’ enrollment

[5]VA is currently working against the perceptions of average veterans that they are entitled to “free” health care and therefore do not need to provide private insurance information. In January 1998, Coopers and Lybrand reported that many veterans are unaware of or unable or unwilling to provide insurance information.

outreach events or when the veteran first visits one of its medical facilities. NJHCS' medical care collections coordinator told us that his office focuses a lot of attention on obtaining accurate insurance information and trying to obtain this information during enrollment rather than during preregistration. NJHCS staff told us that in instances in which a veteran or spouse is employed but does not report having insurance, staff contact the employer to verify whether the veteran has insurance. Also, VISN 3 has contracted with a company that has an insurance information database and has identified additional insured veterans for NJHCS. This has led to additional billings of and collections from insurers. The Houston VA Medical Center has recently contracted with the same company to provide similar services, but results are not yet available.

Some facilities are taking additional steps to verify the accuracy of insurance information. For example, the Houston Medical Center has two staff members whose primary task is to verify insurance coverage. They receive lists of veterans identified as having insurance and then contact insurers to verify coverage. Also, Houston has a system in which each patient's insurance must be reverified every 90 days.

Documentation and Billing of VA Medical Care Needs Improvement

VA's ability to accurately document the non-service-connected care provided to insured veterans and assign the appropriate codes for billing purposes is essential to Veterans Health Administration's (VHA) third-party collections program. VA can bill only for non-service-connected care, and VA staff told us that sometimes the explanations provided for veterans' service-connected disabilities are not specific enough to help physicians determine whether the care they provide is related to service-connected conditions. About 20 percent of medical facilities did not report having procedures to validate whether treatment was for a non-service-connected disability, and less than 70 percent had reported that they trained their staffs in converting the explanation of care provided into codes used to bill insurers.

Failure to properly document care can lead to missed opportunities to bill for care, overpayments by insurers, or denials of VA bills. Also, with the implementation of reasonable charge billing, VA will have to meet the stringent documentation standards imposed on private sector providers by HCFA and private insurers.[6]

[6]VA required that reasonable charge rates be used to bill insurers for care provided on or after September 1, 1999.

VA is trying to improve its medical documentation and billing practices to meet HCFA and private insurer standards. Both of the VA medical facilities we visited are training clinical staff and coders in documenting and coding medical care by HCFA's standards. For example, the Houston Medical Center has obtained assistance from the Baylor College of Medicine to train clinical staff in this area.

Many insurers require that care be precertified (that is, the insurer's approval must be obtained before care is rendered). One of the important services that utilization review staff at medical facilities perform is to obtain in advance from insurers the type and amount of care for which they will pay. Doing this helps increase VA's likelihood of collecting from insurers. VA has trained utilization review staff—many of whom are nurses—on obtaining precertifications from insurers. For example, VA held a national conference for utilization review staff in August 1999. Ninety-eight percent of VA medical facilities reported that they had a precertification process by the third quarter of fiscal year 1999.

More Aggressive Action Is Needed to Follow Up on Debt Collection

Experience suggests that, in general, the longer VA waits to follow up on delinquent bills, the less likely it is to collect on them. As of May 1999, about 75 percent of its delinquent receivables for billed care were more than 90 days old. In June 1998, VA contracted with a collection agency, Transworld Systems, Inc., to assist facilities in collecting third-party bills that are outstanding for more than 90 days. By the third quarter of fiscal year 1999, 48 percent of VA facilities were using the Transworld contract. The facilities send delinquent third-party bills to Transworld, which sends out letters to the insurers on VA's behalf, requesting payment. Both of the facilities we visited use VA's contract with Transworld Systems (the Houston VAMC was a pilot facility for this initiative), which costs VA $4.75 per bill. VA reported collections of more than $9.7 million as a result of this contract at a cost of less than $800,000.

Related GAO Products

Veterans' Affairs: Progress and Challenges in Providing Care to Veterans (GAO/T-HEHS-99-158, July 15, 1999).

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

Veterans' Affairs: Progress and Challenges in Transforming Health Care (GAO/T-HEHS-99-109, Apr. 15, 1999).

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

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