United States Government Accountability Office

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Testimony

Before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EST
Thursday, October 15, 2009

VA HEALTH CARE

Ineffective Medical Center Controls Resulted in Inappropriate Billing and Collection Practices

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GAO

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Highlights of GAO-10-152T, testimony before the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives

VA HEALTH CARE

Ineffective Medical Center Controls Resulted in Inappropriate Billing and Collection Practices

Why GAO Did This Study

GAO was asked to testify on billing practices of the Department of Veterans Affairs (VA). GAO previously reported that continuing problems in billing and collection processes at VA impaired its ability to maximize revenue from private insurance companies (third-party insurers). In June 2008, GAO reported on its follow-up review that (1) evaluated VA billing controls, (2) assessed VA-wide controls for collections, and (3) determined the effectiveness of VA oversight over third-party billings and collections.

To perform the review, GAO conducted case-study analyses of the third-party billing function at 18 medical centers, statistically tested controls over collections VA-wide, and reviewed current oversight policies and procedures. GAO reported the results of this review in GAO-08-675.

What GAO Recommends

In its June 2008 report, GAO made seven recommendations to improve VA's third-party billing and collection processes, including actions to improve (1) third-party billings, (2) follow up on unpaid amounts, and (3) management oversight of billing and collections. VA concurred with all seven recommendations and noted steps it was taking to address them. GAO will follow-up to determine whether, and if so, to what extent, VA has taken action to address our recommendations.

View GAO-10-152T or key components.
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What GAO Found

In June 2008, GAO reported that its case-study analysis of unbilled patient services at 18 medical centers, including 10 medical centers with low billing performance and 8 medical centers under VA's Consolidated Patient Account Centers (CPAC) initiative considered to be high performers, found documentation, coding, and billing errors and inadequate management oversight that resulted in unbilled amounts. The total amount that VA had categorized as unbillable in fiscal year 2007 for these 18 case-study medical centers was approximately $1.7 billion. Although some medical services are not billable, such as service-connected treatment, management had not validated reasons for related unbilled amounts of about $1.4 billion to assure that all billable costs are charged to third-party insurers.

GAO also found excessive time to bill and coding errors. The 10 non-CPAC medical centers reported average days to bill ranging from 109 days to 146 days in fiscal year 2007, compared to VA's goal of 60 days, and significant coding and billing errors and other problems that totaled over $254 million or 21 percent of the total in unbilled medical services costs at those centers. Although GAO determined that CPAC officials performed a more thorough review of billings, GAO's analysis of unbilled amounts for the 8 CPAC centers found problems that accounted for $37.5 million, or about 7 percent, of the total unbilled medical services costs.

GAO's June 2008 report identified significant percentages of cases where required follow-up was not done. These are considered to be control failures. VA guidance requires medical center accounts receivable staff to make up to three follow-up contacts, as necessary, on outstanding third-party insurer unpaid bills, which were $600 million as of September 2007. As shown in the table below, GAO's statistical tests of a random sample of fiscal year 2007 third-party bills identified high control-failure rates related to the requirement for initial, second, and third follow-ups with third-party insurers on unpaid amounts.

Estimated Control Failures on Timely Follow-up on Unpaid Bills

Required follow-up	VA-wide centers	CPAC centers	Non-CPAC centers
Initial	69%	36%	71%
Second	44%	23%	45%
Third	20%	22%	17%

Source: GAO analysis of VA data.

Notes: Tests are of a VA-wide random-probability sample of third-party accounts-receivable data. Failure rates are based on the lower bound of GAO's two-sided, 95 percent confidence interval.

GAO also reported in June 2008 that VA lacked policies and procedures and a full range of standardized reports for effective management oversight of VA-wide third-party billing and collection operations. Further, although VA management has undertaken several initiatives to strengthen processes and controls and enhance third-party revenue, many of these initiatives are open-ended or will not be implemented for several years.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our prior work on the Department of Veterans Affairs' (VA) controls over medical center billings and collections. The department provides health care to eligible veterans through a system of Veterans Health Administration (VHA) medical facilities that constitute one of the largest health care systems in the world. VA is authorized[1] to provide certain medical services to veterans with nonservice-related conditions and to recover some of the cost of providing these additional benefits through billing and collecting payments from veterans' private health insurers, commonly referred to as third-party insurers.[2] VA can also use these third-party health insurance collections to supplement its medical care appropriations. VA third-party billing and collection operations are carried out through a nationwide network of 153 medical centers, 801outpatient clinics, and 135 nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA reported in its fiscal year 2008 performance and accountability report that about 5.5 million people received treatment in VA health care facilities, and VA collections for health care services totaled nearly $2.4 billion.[3]

Since 2001 we have reported that continuing weaknesses in VA billing processes and controls have impaired VA's ability to maximize the collections received from third-party insurers.[4] Most recently, in June 2008 we reported[5] on VA's ineffective controls over medical center billings and

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[1]The Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, § 101, 110 Stat. 3177, 3178 (Oct. 9, 1996) (codified at 38 U.S.C. § 1710) and the Veterans Reconciliation Act of 1997, Pub. L. No. 105-33, tit. VIII, § 8023, 111 Stat. 251, 665 (Aug. 5, 1997) (codified at 38 U.S.C. §1729A).

[2]VA does not bill for health care services provided to veterans who have Medicare coverage only or veterans who have no private health insurance.

[3]VA collections for health care services include third-party collections as well as patient copayments for medical services.

[4]GAO, *VA Health Care: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections*, GAO-01-1157T (Washington, D.C.: Sept. 20, 2001); GAO, *VA Health Care: VA Increases Third-Party Collections as It Addresses Problems in Its Collections Operations*, GAO-03-740T (Washington, D.C.: May 7, 2003); and GAO, *VA Medical Centers: Further Operational Improvements Could Enhance Third-Party Collections*, GAO-04-739 (Washington, D.C.: July 19, 2004).

[5]GAO, *VA Health Care: Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies*, GAO-08-675 (Washington, D.C.: June 10, 2008).

collections. My testimony today summarizes the findings of our June 2008 report that are most relevant to the subject of today's hearing. Specifically, I will focus on our findings concerning (1) the effectiveness of VA medical center billing processes at selected locations, (2) VA controls for performing timely follow-up on outstanding third-party receivables, and (3) the adequacy of VA oversight of billing and collection processes.

To achieve our first objective, we used a case study approach to assess billing controls because VA did not have centralized data on third-party billings. For our case studies, we selected the 10 medical centers with the highest numbers of days to bill (lowest billing performance) and the 8 medical centers under the Consolidated Patient Account Center (CPAC)[6] management initiative for regionalized billing and collection activity that were expected to be high performers. To achieve the second objective, we tested controls for timely collection follow-up and documentation of contacts on third-party bills using a VA-wide statistical sample, and stratified subsets of our VA-wide sample for CPAC medical centers and medical centers that were not under the CPAC initiative. To address our third objective on VA management oversight capability, we reviewed management reports generated by key VA systems and interviewed medical center and VHA officials about their oversight procedures.

We conducted the work for the June 2008 report on which this testimony was based from January 2007 through May 2008 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provided a reasonable basis for our findings and conclusions based on our audit objectives.

[6]One of VA's initiatives to improve billing and collection functions was the establishment of a CPAC pilot program covering 8 medical centers. The CPAC model, based on the private-sector approach, consists of a stand-alone regionalized billing and collections activity supported by data validation, customer service, and other functions.

Case Study Medical Centers' Weaknesses Resulted in Underbillings of Third-Party Insurers

Our 2008 report found significant internal control weaknesses and inadequate management oversight that limited VA's ability to maximize collections from third-party insurers. Our 18 case studies included 10 medical centers with reported low billing performance and the 8 medical centers under the CPAC management initiative for regionalized billing and collection activity that were expected to be high performers. Our case study analysis of unbilled patient services at 18 case study medical centers found excessive average days to bill, coding and billing errors, and a lack of management oversight, which raised questions about why $1.7 billion was not billed to third-party insurers at the 18 locations we reviewed. It is important that coding for medical services is accurate and timely because insurers will not accept improperly coded bills. Moreover, many insurers have national or regional contracts with VA that bar insurer liability for payment of bills received after a specified period of time after the date that medical services were provided, usually 1 year, but sometimes as little as 6 months.

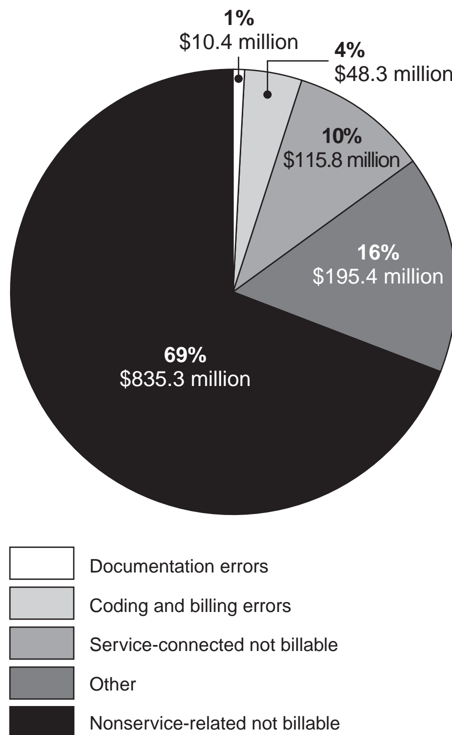
There are valid reasons why some medical services are not billable, including service-connected treatment, Medicare coverage, and the lack of private health insurance coverage.[7] In fiscal year 2007, the 18 medical centers we reviewed had $1.4 billion in unbilled amounts in these categories. We found that medical center management at all 18 of our case study locations did not always validate the reasons these amounts were unbilled.

At the 10 non-CPAC medical centers we reviewed, we identified low billing performance including average days to bill ranging from 109 days to 146 days in fiscal year 2007, compared to VA's goal of 60 days. We also found these centers had significant documentation, coding, and billing errors and performed little or no management oversight of the billing function. As illustrated in figure 1, omissions in documentation ($10.4 million), the use of inaccurate clinical service codes ($48.3 million), and other undefined reasons ($195.4 million) accounted for over $254 million, or 21 percent, of the $1.2 billion in total unbilled medical services costs at the 10 non-CPAC medical centers. The largest group of billing errors included $25 million for which the billing time frame had expired. Managers at the 10 non-CPAC medical centers did not perform adequate reviews of the services assigned to these categories to ensure that billing clerks appropriately

[7] Under 38 U.S.C. § 1729, VA is not authorized to collect these amounts from third-party insurers.

classified them. While not the focus of our audit, such reviews are also critical for effectively identifying and addressing any overbillings.

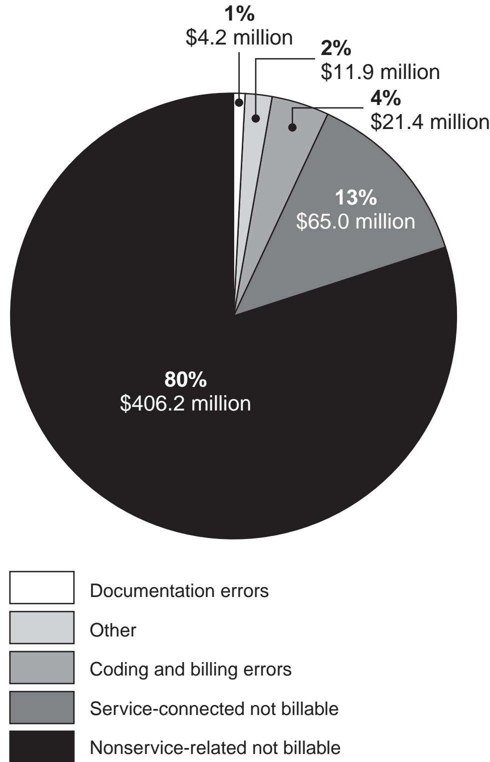
Figure 1: Fiscal Year 2007 Unbilled Amounts by Reason for 10 Medical Centers with the Largest Elapsed Days to Bill



Source: GAO analysis of 10 case study medical centers' Reasons Not Billable data.

Our case study analysis of the eight medical centers under the CPAC initiative, with $508.7 million in unbilled amounts, found that CPAC officials performed a more thorough review of the billing function. Our analysis of fiscal year 2007 unbilled amounts for the eight CPAC centers showed that these centers' average days to bill ranged from 39 days to 68 days, compared to VA's 2007 goal of 60 days. As illustrated in figure 2, CPAC centers' documentation errors ($4.2 million), coding and billing errors ($21.4 million), and other undefined reasons ($11.9 million) accounted for $37.5 million or about 7 percent of medical services costs that were not billed to third-party insurers.

Figure 2: Fiscal Year 2007 Unbilled Amounts by Reason for Eight Medical Centers under CPAC



Source: GAO analysis of 8 CPAC case study medical centers' Reasons Not Billable data.

Medical Centers Have Not Followed VA Policy for Timely Follow-up and Documentation on Unpaid Third-Party Receivables

Our June 2008 report identified significant problems related to timely follow-up and documentation of contacts with third-party insurers on actions to collect outstanding receivables. VA policy[8] requires medical center accounts receivable staff to make up to three follow-up contacts, as necessary, on outstanding third-party receivables, which were $600 million as of September 25, 2007.

Our statistical tests[9] of a stratified random sample of 260 fiscal year 2007 third-party bills identified high percentages of cases where required follow-up was not done, which is considered to be a control failure. These high control failure rates occurred VA-wide, in CPAC and non-CPAC medical centers, as shown in table 1. For example, our tests for the required initial follow-up showed a failure rate of 69 percent VA-wide, 36 percent for CPAC centers, and 71 percent for non-CPAC centers.

Table 1: Estimated Failure Rates for Controls on Timely Follow-up on Unpaid Third Party Insurer Receivables

Required follow-up	VA-wide medical centers	CPAC medical centers	Non-CPAC medical centers
Initial, 45 days	69%	36%	71%
Second, 21 days after first contact	44%	23%	45%
Third, 14 days after second contact	20%	22%	17%

Source: GAO analysis of VA data.

Notes: Tests are of a VA-wide random-probability sample of third-party accounts-receivable data. Failure rates are based on the lower bound of our two-sided, 95 percent confidence interval. Our sample included bills over $250.

The failure to make timely follow-up contacts and delays in initiating contacts with third-party insurance companies on unpaid amounts increase the risk that payments will not be collected, or that payments will be substantially delayed. Of the population of fiscal year 2007 billings that were used for our stratified random sample, VA had collected about 47

[8]VA Handbook 4800.14, *Medical Care Debts*, Section 4 (b) (1).

[9]Our statistical tests were based on a 95 percent, 2-sided confidence interval. Because confidence intervals varied widely for our various control tests, we used a conservative estimate of our test results that is based on the lower bound of our confidence intervals. Our sample included bills over $250.

percent as of September 25, 2007.[10] Our analysis of accounts receivable aging data showed that 6.25 percent of the receivables balance as of the end of fiscal year 2007 was over 1 year old.[11]

VA policy requires that accounts receivable staff include a comment for any adjustments[12] to decrease outstanding third-party bills. The policy requires that the explanation be clear and unambiguous and state the particular reason for the adjustment. Our tests of whether accounts receivable personnel adequately documented reasons for adjustments to decrease a bill found a failure rate of 38 percent VA-wide. Without clear documentation of the reasons for billing adjustments, VA management lacks the ability to monitor the validity of the adjustments. Further, the lack of follow-up documentation undermines the reliability of trend information needed to effectively manage third-party receivables.

Management officials at several of the medical centers tested in our statistical sample attributed their high follow-up failure rate to inadequate staffing. However, we found that a lack of management oversight at the medical centers as well as at the VHA management level contribute to the control weaknesses we identified. In addition, we found that VHA and medical centers have few standardized management reports to facilitate oversight. Similar to the billings process, we found that the case study medical centers have limited procedures in place to monitor the collections process. Moreover, uncollected third-party receivables place an added burden on taxpayers because additional amounts would need to be covered by annual appropriations to support the same level of service to veterans.

[10]The stratified random sample population was valued at $547.8 million and VA had collected about $260.1 million as of September 25, 2007.

[11]Specifically, $37.5 million of the total $600 million in receivables as of the end of fiscal year 2007 was over 1 year old.

[12]Accounts receivable staff reduce third-party receivables for a variety of reasons including, but not limited to, partial payments when the amount received is the full amount expected from the insurance carrier, the amount of payment received is the usual and customary amount received from the insurance company, or medical services are not covered under the insurance policy.

VA Lacks Policies and Procedures for Assuring Adequate Oversight of Third-Party Billings and Collections

In June 2008 we reported that there were no formal policies and procedures for oversight of the third-party insurer billing and collection processes by medical centers or VHA. As a result, we found little or no monitoring and oversight of the third-party billing and collection processes. This raises concerns about the adequacy of oversight over the $1.7 billion in unbilled amounts at the 18 case study medical centers, including the hundreds of millions of dollars in unbilled amounts related to coding, billing, and documentation errors, and other undefined reasons. The lack of formal VA policies for management oversight of third-party billings and collections also raises VA-wide concerns.

In addition, we found that medical centers and VHA had few standardized management reports to facilitate oversight. For example, our review of VHA's Chief Business Office (CBO) reports found that these reports generally consisted of data on VA-wide days to bill, accounts receivable, and collections. VHA CBO did not generate detailed performance reports by medical center, and it did not review data on the status of unbilled amounts. We noted that limitations in management reporting related to VHA systems design. Specifically, VA's health care billing and collection systems operated as stand-alone systems at each medical center. As such, VA-wide reporting was dependent on numerous individual queries and data calls. Enhanced oversight would permit VHA and medical center management to monitor trends and performance metrics, such as increases or decreases in unbillable amounts.

In summary, while our 2008 report focused on VA underbillings and related control weaknesses, the weaknesses we identified could also result in VA overbillings to third-party insurance companies or veterans. For example, inaccurate data entry could result in bills for services to veterans for service-connected illnesses or conditions. Nonetheless, VA has made some progress in improving policy guidance and processes for billing and collecting medical care receivables from third-party insurers. In our 2008 report, we noted, but did not assess, that VA management had undertaken several initiatives to strengthen processes and controls over third-party billings and collections. For example, VA had completed initiatives for (1) recruitment and retention of coders and health information managers and (2) updating VHA policy guidance related to third-party revenue. In addition, VA had six key strategic initiatives, including CPAC, under way to enhance revenue from third-party insurers. Until VA addresses its significant, continuing weaknesses in controls over coding, billing, and collections follow-up that prevent it from maximizing revenue from third-party insurance companies, it will continue to be at risk of millions in

erroneous billings. These errors negatively affect VA's ability to provide medical care to the nation's veterans.

Our June 2008 report included seven recommendations to VA aimed at strengthening key internal control activities over third-party billings and collections and improving management oversight. In comments on a draft of that report, VA concurred with all seven of our recommendations and provided information on steps it is taking to address them. We will follow up to determine whether, and if so, to what extent VA has taken action to address our recommendations.

Mr. Chairman and Ranking Member Brown, this concludes my prepared statement. I would be happy to respond to any questions you or other members of the subcommittee may have at this time.

Contact and Acknowledgments

For further information about this testimony, please contact Kay L. Daly, Director, Financial Management and Assurance at (202) 512-9095, or dalykl@gao.gov. Contact points for our offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Major contributors to this testimony included Gayle L. Fischer, Assistant Director; Carla J. Lewis, Assistant Director; F. Abe Dymond, Assistant General Counsel; Carl S. Barden; Deyanna J. Beeler; Francine DelVecchio; Lauren S. Fassler; Patrick T. Frey; Jason Kelly; Amanda K. Miller; Meg Mills; Matthew L. Wood; and Matthew P. Zaun.

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