

GAO

Report to the Chairman, Subcommittee  
on Oversight and Investigations,  
Committee on Veterans' Affairs, House  
of Representatives

January 2003

## VA HEALTH CARE

# Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations



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# Highlights

Highlights of [GAO-03-145](#), a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

## Why GAO Did This Study

The Department of Veterans Affairs (VA) collects health insurance payments, known as third-party collections, for veterans' health care conditions it treats that are not a result of injuries or illnesses incurred or aggravated during military service. In September 1999, VA adopted a new fee schedule, called "reasonable charges," that it anticipated would increase revenues from third-party collections.

In 2001, GAO testified that problems in VA's collections operations diminished VA's collections. For this report, GAO was asked to examine VA's third-party collections and problems in collections operations for fiscal year 2002 as well as its initiatives to improve collections.

## VA HEALTH CARE

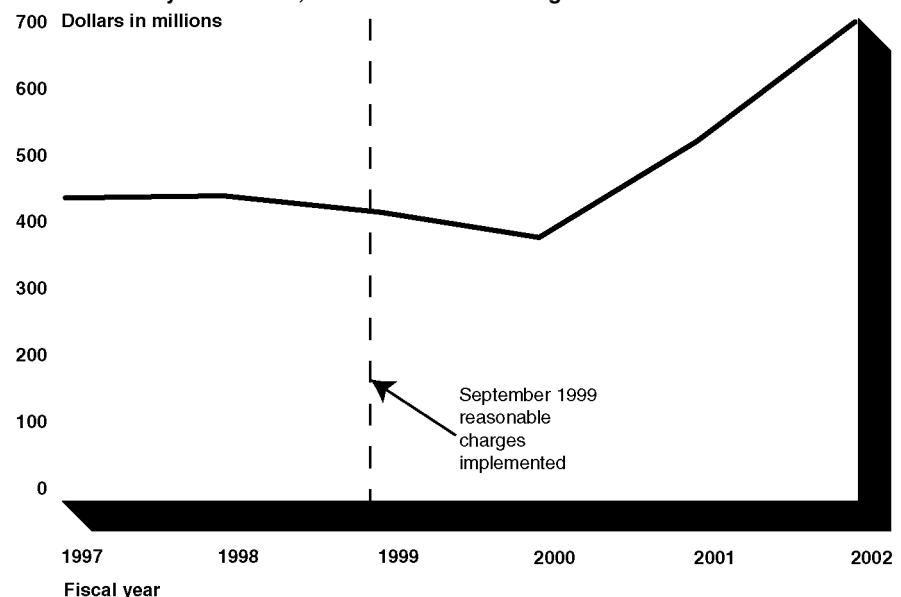
# Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations

## What GAO Found

VA's fiscal year 2002 third-party collections rose by 32 percent, continuing an upward trend that began in fiscal year 2001. The increase in collections reflected VA's improved ability to manage the larger billing volume and more itemized bills required under its new fee schedule. Billings increased mainly due to a reduction of billing backlogs and improved collections processes—such as better medical documentation prepared by physicians, more complete identification of billable care by coders, and more bills prepared per biller—according to VA managers in three regional health care networks. However, VA continues to address operational problems, such as missed billing opportunities, that limit the amount VA collects.

To address operational problems and further increase collections, VA has several initiatives under way and is developing additional ones. VA has been implementing initiatives in its 2001 improvement plan that was designed to address operational problems, such as unidentified insurance for some patients, insufficient documentation of services for billing, shortages of coding staff, and insufficient pursuit of accounts receivable. VA's last formal status report in May 2002 designated only 8 of the plan's 15 initiatives scheduled for completion by that time as having been completed. VA continues implementation of this plan and is also developing new initiatives, such as an automated financial system to better serve billing needs. It is too early to evaluate the extent to which VA's full implementation of its 2001 plan and new initiatives will be able to address operational problems and further increase third-party collections. In commenting on a draft of this report, VA generally agreed with our findings

VA's Third-Party Collections, Fiscal Years 1997 through 2002



Source: VA Revenue Office.

[www.gao.gov/cgi-bin/getrpt?GAO-03-145](http://www.gao.gov/cgi-bin/getrpt?GAO-03-145).

To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

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# Contents

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<b>Letter</b>		1
	Results in Brief	2
	Background	3
	Collections Are Increasing, but Operational Problems Limit Insurance Payments	5
	VA Is Implementing Planned Actions and Developing Other Initiatives to Address Problems in Collections Operations	9
	Concluding Observations	14
	Agency Comments and Our Evaluation	14
<b>Appendix I</b>	<b>Scope and Methodology</b>	16
<b>Appendix II</b>	<b>Comments from the Department of Veterans Affairs</b>	18
<b>Table</b>		
	Table 1: Percentage Increases in Collections for Networks Selected for Study, October 2000 through February 2001 Compared to October 2001 through February 2002	17
<b>Figures</b>		
	Figure 1: VA's Third-Party Collections Processes	4
	Figure 2: VA's Third-Party Collections, Fiscal Years 1997 through 2002	6
	Figure 3: Improvement Plan's Actions Designated as Completed by VA, as of May 25, 2002	11

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## Abbreviations

HMO	health maintenance organization
PFSS	Patient Financial Services System
VA	Department of Veterans Affairs
VHA	Veterans Health Administration



United States General Accounting Office  
Washington, DC 20548

January 31, 2003

The Honorable Steve Buyer  
Chairman  
Subcommittee on Oversight and Investigations  
Committee on Veterans' Affairs  
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) provides health care to eligible veterans and, under certain circumstances, VA is authorized to collect reasonable charges from their health insurers. Specifically, VA can bill insurers for treatment of conditions that are not a result of injuries or illnesses incurred or aggravated during military service.<sup>1</sup> VA cannot bill for health care conditions that result from military service, nor is it generally authorized to collect from Medicare and Medicaid. In fiscal year 2002, VA collected \$687 million in insurance payments, which are known as third-party collections. These collections were VA's largest source of revenue to supplement its \$21 billion medical care appropriation, and they helped pay for veterans' growing demand for care. The total number of veterans VA treated has increased from 2.6 million in fiscal year 1996 to 3.8 million in fiscal year 2001, and VA predicts continuing growth in its patient workload.<sup>2</sup>

Over the past several years, we and others have raised concerns about VA's ability to maximize its third-party collections to enhance revenue. For example, a VA Inspector General report stated that VA missed billing opportunities, had billing backlogs, and did inadequate follow-up on accounts receivable in fiscal years 2000 and 2001.<sup>3</sup> We testified in September 2001 that problems in VA's collections operations—such as inadequate patient intake procedures to gather insurance information,

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<sup>1</sup>VA cannot collect payments from certain insurers. For example, VA cannot collect payments from health maintenance organizations (HMOs) when VA is not a participating provider.

<sup>2</sup>According to VA's estimate, there were about 25 million veterans in 2001.

<sup>3</sup>VA Office of Inspector General, *Audit of the Medical Care Collection Fund Program*, Report No. 01-00046-65 (Washington, D.C.: Feb. 26, 2002).

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insufficient physician documentation, a shortage of qualified coders, and insufficient automation—diminished VA’s collections.<sup>4</sup>

At your request, we have examined VA’s progress with third-party collections since September 2001. In this report, we are providing an update on (1) VA’s third-party collections and problems in collections operations for fiscal year 2002 and (2) VA’s initiatives to improve collections. To conduct our review, we examined VA’s collections data for fiscal years 2001 and 2002; reviewed relevant VA documents, such as its 2001 collections improvement plan; and interviewed officials in VA headquarters and in 3 of VA’s 21 health care networks<sup>5</sup>—Network 2 (Albany), Network 9 (Nashville), and Network 22 (Long Beach)—to better understand the reasons for increased collections. Our work was performed from February 2002 through January 2003 in accordance with generally accepted government auditing standards. For more details on our scope and methodology, see appendix I.

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## Results in Brief

VA’s third-party collections for fiscal year 2002 totaled \$687 million, 32 percent more than for fiscal year 2001. VA’s increased collections have resulted from VA’s submitting more insurance bills and receiving more payments than in the prior year. Billings increased mainly due to a reduction of billing backlogs and improved collections processes—such as better medical documentation prepared by physicians, more complete identification of billable care by coders, and more bills prepared per biller—according to VA managers in three health care networks. Although VA reported improvements, we found that operational problems, such as missed billing opportunities, continued to limit collections. As a result, VA lacks a reliable estimate of uncollected dollars and therefore does not have the basis to assess its systemwide operational effectiveness.

To further improve collections, VA has several initiatives under way and is developing additional ones. In September 2001, VA produced its Veterans Health Administration Revenue Cycle Improvement Plan that included 24 actions to improve collections by addressing problems, such as

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<sup>4</sup>U.S. General Accounting Office, *VA Health Care: VA Has Not Sufficiently Explored Alternatives for Optimizing Third-Party Collections*, [GAO-01-1157T](#) (Washington, D.C.: Sept. 20, 2001).

<sup>5</sup>The management of VA’s hospitals and other health care facilities is decentralized to 21 regional networks.

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unidentified insurance for some patients and gaps in the automated capture of billing data. However, VA's last formal status report in May 2002 designated only 8 of these actions as completed, although 15 were scheduled for completion by that time. The plan is scheduled for full implementation by the end of 2003. In May 2002 VA also established the Chief Business Office in its Veterans Health Administration (VHA) to direct VHA's Revenue Office and to develop a new approach for VA's collections activity. VA officials told us that the new approach will combine the improvement plan's actions with additional initiatives, such as the development of an automated financial system that better serves billing needs. The new approach is also intended to establish additional performance measures and standards for oversight of collections units' performance and to strengthen VA's understanding of how to improve collections. However, it is too early to evaluate the extent to which VA will be able to address operational problems and further increase collections by fully implementing its 2001 plan and new approach.

In commenting on a draft of this report, VA generally agreed with our findings. VA suggested that our title should emphasize its effort to build infrastructure for effective collections operations rather than its continuing effort to address problems in collections operations. We believe that our title is accurate because VA continues to address problems that we and others have identified in VA's collections operations.

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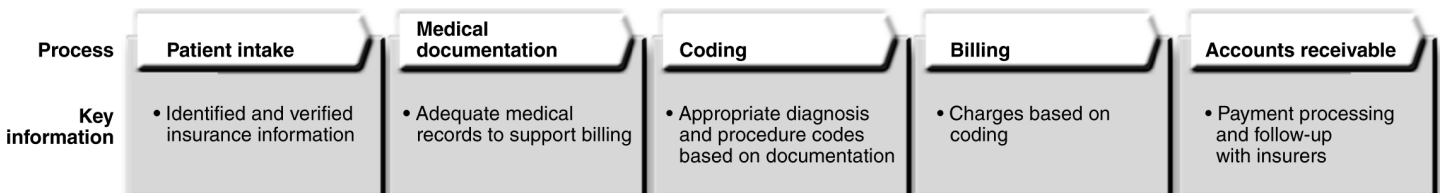
## Background

Although VA has been authorized to collect third-party health insurance payments since 1986, it was not allowed to use these funds to supplement its medical care appropriations until enactment of the Balanced Budget Act of 1997. Part of VA's 1997 strategic plan was to increase health insurance payments and other collections to help fund an increased health care workload. The potential for increased workload occurred in part because the Veterans' Health Care Eligibility Reform Act of 1996 authorized VA to provide certain medical care services not previously available to veterans without service-connected disabilities or low incomes. VA expected that collections from third-party payments, copayments, and deductibles would cover the majority of costs for higher-income veterans without service-connected disabilities. These veterans increased from about 4 percent of all veterans treated in fiscal year 1996 to about 20 percent in fiscal year 2001.

To collect from health insurers, as shown in figure 1, VA uses five related processes to manage the information needed to bill and collect. The patient intake process involves gathering insurance information and

verifying that information with the insurer. The medical documentation process involves properly documenting the health care provided to patients by physicians and other health care providers. The coding process involves assigning correct codes for the diagnoses and medical procedures based on the documentation. Next the billing process serves to create and send bills to insurers based on the insurance and coding information. Finally, the accounts receivable process includes processing payments from insurers and following up with insurers on outstanding or denied bills.

**Figure 1: VA's Third-Party Collections Processes**



Source: VA.

In 1999, VA adopted a new fee schedule, called “reasonable charges,” which are itemized fees based on diagnoses and procedures, and the new schedule allows VA to bill in a way that more accurately captures the care provided. Previously, VA had nine charges for inpatient care and one charge for outpatient care. These charges were not specific to the care provided. For example, VA had charged the same per diem rate for any patient in a surgical bed section regardless of the care provided. In addition, before adopting the new fee schedule, VA had billed all outpatient visits, including surgery, based on VA’s average outpatient cost of \$229, a single rate that had limited VA’s ability to collect higher amounts for more expensive care. In contrast, when the reasonable charges fee schedule was adopted in September 1999, an outpatient hernia surgery charge increased to about \$6,500; and an office visit charge for an established patient decreased to a range of about \$22 to \$149, depending on the care given.<sup>6</sup>

<sup>6</sup>These amounts reflected the national average charges in September 1999 for the services specified. To reflect the amounts charged by other local providers, the charges that VA actually bills vary by the locality in which VA services are provided.

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By linking charges to the care provided, VA created new bill-processing demands—particularly in the three areas of documenting care, coding that care, and processing bills per episode of care. First, VA must be prepared to provide an insurer supporting medical documentation for the itemized charges. Second, VA must accurately assign medical diagnoses and procedure codes to set appropriate charges, a task which requires coders to search through medical documentation and various databases to identify all billable care. Third, in contrast to a single bill for an episode of care under the previous fee schedule, under reasonable charges VA must prepare a separate bill for each provider involved in the care and an additional bill if a hospital facility charge applies.

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## Collections Are Increasing, but Operational Problems Limit Insurance Payments

For fiscal year 2002, VA collected third-party payments of \$687 million, a 32 percent increase over its fiscal year 2001 collections. The increased collections in fiscal year 2002 resulted from VA's submitting and collecting for more bills than previously. According to three network revenue managers we interviewed, billings increased mainly because of a reduction of billing backlogs and improvements in the processes necessary to collect under the new reasonable charges fee schedule. Nevertheless, VA's ability to collect was limited by problems such as missed billing opportunities. VA does not know how many dollars remain uncollected because of such limitations.

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## Third-Party Collections Increased

For fiscal year 2002, VA collected \$687 million, up 32 percent compared to the \$521 million collected during fiscal year 2001. The increased collections reflected VA's processing a higher volume of bills than it did in the prior fiscal year. VA processed and received payments for over 50 percent more bills in fiscal year 2002 than in fiscal year 2001. VA's collections grew at a lower percentage rate than the number of paid bills because the average payment per paid bill dropped 18 percent compared to the prior fiscal year. Average payments dropped primarily because a rising proportion of VA's paid bills were for outpatient care rather than inpatient care. Since the charges for outpatient care were much lower on average, the payment amounts were typically lower as well.

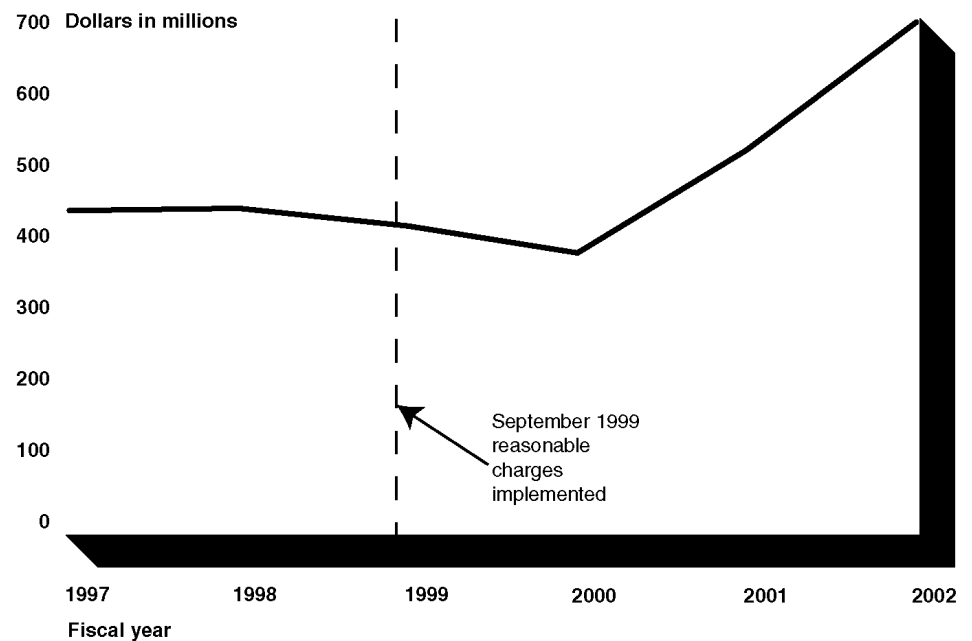
VA had difficulties establishing the collections processes to bill under a new fee schedule, processes which were necessary to achieve the increased billing and collections in fiscal year 2002. Although VA anticipated that the shift to reasonable charges would yield higher collections, collections dropped in fiscal year 2000 after implementing the new fee schedule in September 1999. VA attributed that drop to its being



unprepared to bill under reasonable charges, particularly because of its lack of proficiency in developing medical documentation and coding to appropriately support a bill. As a result, VA reported that many VA medical centers developed billing backlogs after initially suspending billing for some care.

As shown in figure 2, VA's third-party collections increased in fiscal year 2001—reversing fiscal year 2000's drop in collections—and increased again in fiscal year 2002. After initially being unprepared in fiscal year 2000 to bill reasonable charges, VA began improving its implementation of the processes necessary to bill and increase its collections. According to VA, by the summer of 2000, facilities had sufficiently implemented processes to move forward with billing under reasonable charges. By the end of fiscal year 2001, VA had submitted 37 percent more bills to insurers than in fiscal year 2000. VA submitted even more in fiscal year 2002, over 8 million bills that constituted a 54 percent increase over the number in fiscal year 2001.

**Figure 2: VA's Third-Party Collections, Fiscal Years 1997 through 2002**



Source: VA Revenue Office.

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VA officials cited various sources for an increased number of bills in fiscal year 2002. Managers we spoke with in three networks—Network 2 (Albany), Network 9 (Nashville), and Network 22 (Long Beach)—mainly attributed the increased billing to reductions in billing backlogs. They also cited an increased number of patients with billable insurance as a factor for the increased billing. In addition, a May 2001 change in the reasonable-charges fee schedule for medical evaluations allowed billing for a facility charge in addition to billing for the professional service charges, a change that contributed to the higher volume of bills in fiscal year 2002.

Increased collections for fiscal year 2002 reflected VA's improved ability to manage the volume and billing processes required to produce multiple bills under reasonable charges, according to three network revenue managers. Networks 2 (Albany) and 9 (Nashville) reduced backlogs, in part by hiring more staff, contracting for staff, or using overtime to process bills and accounts receivable. Network 2 (Albany), for instance, managed an increased billing volume through mandatory overtime for billers. Managers we interviewed in all three networks noted better medical documentation provided by physicians to support billing. In Network 22 (Long Beach) and Network 9 (Nashville), revenue managers reported coders were getting better at identifying all professional services that can be billed under reasonable charges.<sup>7</sup> In addition, the revenue manager in Network 2 (Albany) said that billers' productivity had risen from 700 to 2,500 bills per month over a 3-year period, as a result of gradually increasing productivity standards and a streamlining of their jobs to focus solely on billing.

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### Operational Problems Limit Collections, but VA Lacks an Estimate of Uncollected Dollars

Studies have suggested that operational problems—missed billing opportunities, billing backlogs, and inadequate pursuit of accounts receivable—limited VA's collections in the years following the implementation of reasonable charges. After examining activities in fiscal years 2000 and 2001, a VA Inspector General report estimated that VA could have collected over \$500 million more than it did.<sup>8</sup> About 73 percent of this uncollected amount was attributed to a backlog of unbilled medical

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<sup>7</sup>The revenue manager in Network 9 (Nashville) said that coders were getting better at the manual searching that is required to find billable professional services and laboratory tests. During fiscal year 2001, coders missed some billable care because of inadequate searches through the various sources of information that document services and tests.

<sup>8</sup>VA Office of Inspector General, Report No. 01-00046-65.

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care; most of the rest was attributed to insufficient pursuit of delinquent bills. Another study, examining only professional-service charges in a single network, estimated that \$4.1 million out of \$4.7 million of potential collections was unbilled for fiscal year 2001.<sup>9</sup> Of that unbilled amount, 63 percent was estimated to be unbillable primarily because of insufficient documentation. In addition, the study found coders often missed services that should have been coded for billing.

According to the Director of the Revenue Office, VA could increase collections by working on operational problems. These problems included unpaid accounts receivable and missed billing opportunities due to insufficient identification of insured patients, inadequate documentation to support billing, and coding problems that result in unidentified care. During April through June 2002, three network revenue managers told us about backlogs and processing issues that persisted into fiscal year 2002. For example, although Network 9 (Nashville) had above average increases in collections for both inpatient and outpatient care, it still had coding backlogs in four of six medical centers. According to Network 9's (Nashville) revenue manager, eliminating the backlogs for outpatient care would increase collections by an estimated \$4 million for fiscal year 2002, or 9 percent.<sup>10</sup> Additional increases might come from coding all inpatient professional services, but the revenue manager did not have an estimate because the extent to which coders are capturing all billable services was unknown. Moreover, although all three networks reported that physicians' documentation was improving for billing, they reported a continuing need to improve physicians' documentation. In addition, Network 22 (Long Beach) reported that accounts receivable staff had difficulties keeping up with the increased volume of bills because it had not hired additional staff or contracted help for accounts receivable.

As a result of these operational limitations, VA lacks a reliable estimate of uncollected dollars, and therefore does not have the basis to assess its systemwide operational effectiveness.<sup>11</sup> Some uncollected dollars resulting

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<sup>9</sup>Economic Systems, Inc. and AdvanceMed, *Professional Fee Backlog Assistance: Final Technical Report*, a report prepared for the Department of Veterans Affairs, March 5, 2002.

<sup>10</sup>In September 2002, the revenue manager anticipated that the backlog would be reduced to \$2 million by the end of fiscal year 2002 because the medical centers had hired new coders and the network had created a central pool of seven coders.

<sup>11</sup>In addition, VA does not know the net impact of actual third-party collections on supplementing its annual appropriation for medical care. This is because, according to VA officials, VA does not have a way to routinely capture its full collections costs.

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from currently missed billing opportunities—such as billable care missed in coding—are not readily quantified. Other uncollected dollars—such as those from backlogged bills and uncollected accounts receivable—are either only partially quantifiable or their potential contribution to total collections is uncertain. For example, even though the uncollected dollars in older accounts receivable can be totaled, the yield in payments through more aggressive pursuit of accounts receivable is uncertain. This is because, according to VA officials, some portion of the billed dollars is not collectable due to VA inappropriately billing for services not covered by the insurance policy, billing against a terminated policy, or not closing out the accounts receivable after an insurer paid the bill.<sup>12</sup>

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## VA Is Implementing Planned Actions and Developing Other Initiatives to Address Problems in Collections Operations

VA continues to implement its 2001 improvement plan and is planning more improvements. Although the improvement plan could potentially improve operations and increase collections, it is not scheduled for full implementation until December 2003. In May 2002, VA created a new office in VHA, the Chief Business Office, in part to address collections issues. According to VA officials, this office is developing a new approach to improvements, which will include initiatives beyond those in the improvement plan.

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## 2001 Plan to Improve Collections Is Partially Implemented

VA's improvement plan was designed to increase collections by improving and standardizing its collections processes. The plan's 24 actions are to address known operational problems affecting revenue performance. These problems include unidentified insurance for some patients, insufficient documentation for billing, shortages of coding staff, gaps in the automated capture of billing data, insufficient pursuit of accounts receivable, and uneven performance across collections sites.

The plan seeks increased collections through standardization of policy and processes in the context of decentralized management, in which VA's 21 network directors and their respective medical center directors have

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<sup>12</sup>VA's accounts receivable totals are larger than what is collectible, in part, because VA includes the entire amount of charges for veterans covered by Medicare, when those veterans have Medicare supplemental insurance. Although VA cannot generally collect from Medicare, it includes the total as part of its billing process to the supplemental insurers to determine the proportion of charges the supplemental insurers will pay.

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responsibility for the collections process. Since management is decentralized, collections procedures can vary across sites. For example, sites' procedures can specify a different number of days waited until first contacting insurers about unpaid bills and can vary on whether to contact by letter, telephone, or both. The plan intends to create greater process standardization, in part, by requiring certain collections processes, such as the use of electronic medical records to provide coders better access to documentation and legible records.

When fully implemented, the plan's actions can improve collections to the extent that they can reduce operational problems such as missed billing opportunities. For example, two of the plan's actions—requiring patient contacts prior to scheduled appointments to gather insurance information and electronically linking VA to major insurers to identify patients' insurance—are intended to increase the number of patients identified with insurance. A recent study estimated that 23.8 percent of VA patients in fiscal year 2001 had billable care, but VA actually billed for the care of only 18.3 percent of patients.<sup>13</sup> This finding suggests that VA could have billed for 30 percent more patients than it actually billed.

VA has implemented some of the improvement plan's 24 actions, which were scheduled for completion at various times through 2003, but is behind the plan's original schedule. The plan had scheduled 15 of the 24 actions for completion through May 25, 2002, but, as shown in figure 3, VA had designated only 8 as completed, as of the last formal status report on the plan in May 2002.<sup>14</sup>

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<sup>13</sup>T. Michael Kashner, Ph.D., J.D., et al., *Final Report: Veterans Affairs Patient Health Insurance Survey (VAPHIS)*, a survey funded by the Department of Veterans Affairs, February 16, 2002. The Chief Business Officer told us that his office plans to do another survey to confirm its results.

<sup>14</sup>A Chief Business Office official stated in September 2002 that the office plans to develop a status report that includes the improvement plan as well as other actions in its new approach.

**Figure 3: Improvement Plan's Actions Designated as Completed by VA, as of May 25, 2002**

Process	Improvement plan actions and intended outcomes	Actions designated as completed
Patient intake	1. Mandate preregistration contact of veterans to verify or update insurance information prior to a scheduled appointment. <sup>a</sup>	●
	2. Define standards for patient registration data to ensure capture of the information needed for billing.	
	3. Develop and implement veteran education program to better inform veterans about the importance of providing accurate insurance information.	●
	4. Develop and implement employee education program to provide techniques for requesting patient information and help employees understand the importance of gathering it.	
	5. Implement electronic insurance identification and verification to more completely identify all patients' insurance and provide more timely verification of insurance policy information.	
	6. Consolidate insurance information to provide a national resource for identifying and verifying patient insurance information and limit redundancies in patient intake activities nationally.	
	7. Develop an employer master file to aid insurance identification based on the patient's employer.	
Medical documentation	8. Enforce national documentation policy to improve the quality and timeliness of documentation and reduce the time required to bill.	●
	9. Mandate the use of electronic medical records to improve access to, and legibility of, the information needed for determining medical codes and charges. <sup>a</sup>	●
	10. Develop national program to educate clinicians about documentation and coding skills and their role in collections.	
	11. Develop and mandate the use of electronic patient encounter forms and documentation templates to better ensure complete documentation to support billing. <sup>a</sup>	
	12. Develop and implement tracking system to monitor timely completion of documentation.	
Coding	13. Develop plan to address current coding staff deficiencies in order to increase the accuracy and speed of coding.	
	14. Mandate the use of encoder software, which provides electronic assistance for accurate coding. <sup>a</sup>	●
	15. Develop national standard for laboratory, radiology, and other test names and corresponding medical procedure codes to allow more consistent, accurate, and timely coding.	
Billing	16. Mandate minimum access for billing staff to electronic information for laboratory, radiology, and surgery events, which allows for identification of more billable events. <sup>a</sup>	●
	17a. Complete implementation of the electronic billing project to electronically detect billing errors and speed the delivery of bills to insurers.	b
	b. Complete implementation of the Medicare Remittance Advice project, which allows VA to more appropriately bill Medigap and Medicare supplemental insurers.	
	18. Implement "claims analyzer" tools, which can identify data and coding errors when a bill is created.	●
Accounts receivable	20. Consolidate or outsource accounts receivable follow-up in a onetime effort to collect older accounts receivables.	
	21. Develop utilization review program to educate staff how to support the revenue process, including appeals of payment denials.	
	22. Request VA General Counsel to more aggressively pursue "referred" third party accounts receivable to collect on outstanding bills	●
	23. Implement electronic insurance payments for more efficient and lower-cost processing of payments.	
	24. Implement software for the effective management of accounts receivable to increase collections.	

Source: Veterans Health Administration Revenue Cycle Improvement Plan (September 2001) and VA Revenue Office.

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<sup>a</sup>Certain actions are mandated in the plan, that is, are required, but these actions are not legal or regulatory mandates.

<sup>b</sup>VA designated the electronic billing project, shown here as “17a,” as completed. However, this indicated only partial completion of action 17, which includes an additional project.

Some of the plan’s actions that VA has designated as completed needed additional work. For example, although VA designated electronic billing as completed in the May 2002 report, in August 2002 a VA official indicated that 20 hospitals were still working on a step required to transmit bills to all payers. In other cases, VA has designated an action completed by mandating it in a memorandum or directive. However, mandating an action in the past has not necessarily ensured its full implementation. For example, although an earlier 1998 directive required patient preregistration, the 2001 improvement plan reported that preregistration was not implemented consistently across VA and thus mandated its use.<sup>15</sup>

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## VA Is Developing Other Improvement Initiatives

Officials in VHA’s new Chief Business Office told us that this office is developing a new approach for improving third-party collections. According to the Chief Business Officer, the Under Secretary of Health proposed, and the Secretary approved, the establishment of the Chief Business Office to underscore the importance of revenue, patient eligibility, and enrollment functions; and to give strategic focus to improving these functions. He said the new approach can help increase revenue collections by further revising processes and providing a new business focus on collections.

Officials in this office told us that the new approach will combine these and other actions with the actions in the improvement plan. For example, the Chief Business Office’s improvement strategy incorporates electronic transmission of bills and of third-party payments, which are part of the 2001 improvement plan. The new approach also encompasses initiatives beyond the improvement plan, such as the one in the Under Secretary of Health’s May 2002 memorandum that directed all facilities to refer accounts receivable older than 60 days to a collection agency, unless a facility can document a better in-house process. According to the Deputy Chief Business Officer, this initiative has shown some sign of success—with outstanding accounts receivables dropping from \$1,378 million to

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<sup>15</sup>VA issued a 2002 directive to reemphasize the administrative mandate.

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\$1,317 million from the end of May to the end of July 2002, a reduction of about \$61 million or 4 percent.

Another initiative in the new approach is the Patient Financial Services System (PFSS). PFSS is an automated financial system focused on patient accounts, which is intended to overcome operational problems in VA's current automated billing system. For example, VA's automated system for clinical information was not designed to provide all of the episode-of-care information, such as the health care provider and diagnoses, that are required for billing. The development of PFSS is tied to a demonstration project of a financial system, which is now being designed for Network 10 (Cincinnati).<sup>16</sup> According to the Deputy Chief Business Officer, VA anticipates awarding a PFSS contract by April 1, 2003. The Chief Business Office's plan is to install this financial system in other facilities and networks if it is successfully implemented in the Network 10 (Cincinnati) demonstration.

The Chief Business Office also intends to improve collections by developing better performance measures, which will be similar to those used in the private sector.<sup>17</sup> For example, the office intends to use the measure of gross days revenue outstanding, which indicates the pace of collections relative to the amount of accounts receivable. During fiscal year 2003, the office plans to hold network and facility directors accountable for collections through standards that are tied to these performance measures. In addition, the Chief Business Officer said that tracking performance with these measures could help identify further opportunities for collections improvements.

The Chief Business Office is developing the new initiatives, which it had not formalized into a planning document as of August 2002. Certain key decisions were under consideration. For example, the Chief Business

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<sup>16</sup>In the conference report accompanying its fiscal year 2002 appropriation, VA was directed to begin a demonstration project of a contractor-installed and operated patient financial services system. H.R. Conf. Rep. No. 107-272, at 56 (2001).

<sup>17</sup>As we noted in our 2001 testimony, VA's performance does not compare favorably to some industry benchmarks, such as the number of days required to bill. However, comparisons between VA and the private sector should take into account how VA's processes differ from those in the private sector. For instance, VA has the additional step of determining whether the care is service-connected, and VA bills for both facility and physician charges whereas private sector hospitals may only bill for facility charges. To make comparisons with industry benchmarks more relevant, VA is considering adjustments to its new measures.



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Officer was considering whether to centralize some processes at the network or national level and was developing the performance standards that would be required for holding network and facility directors accountable. Moreover, according to the Chief Business Officer, implementing PFSS will require the office to resolve some issues, including making its existing systems provide sufficient data to support the new financial system.

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## Concluding Observations

As VA faces increased demand for medical care, third-party collections for nonservice-connected conditions remain an important source of alternative revenue to supplement VA's resources. Our work and VA's continuing initiatives to improve collections suggest that VA could collect additional supplemental revenues because it has not collected all third-party payments that it could in fiscal year 2002. However, VA does not have an estimate of the amount of uncollected dollars, which it needs to assess the effectiveness of its current processes.

VA has been improving its billing and collecting under the new fee schedule established in 1999, but VA has not completed its efforts to address problems in collections operations. In this regard, fully implementing VA's 2001 improvement plan could help VA maximize future collections by addressing problems such as missed billing opportunities. However, the plan's reliance on directives, in some cases, to achieve increased collections is not enough to ensure full implementation and optimal performance. The Chief Business Office's new approach could also enhance collections. VA's new Chief Business Office's challenge is to ensure such performance by identifying root causes of problems in collections operations, providing a focused approach to addressing the root causes, establishing performance measures, and holding responsible parties accountable for achieving the performance standards. However, it is too early to evaluate the extent to which VA will be able to address operational problems and further increase collections by fully implementing its 2001 plan and new approach.

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## Agency Comments and Our Evaluation

The Department of Veterans Affairs provided written comments on a draft of this report, which are found in appendix II. VA generally agreed with our findings that it continues to make improvements in increased collections and VHA's Business Office is developing new initiatives to further enhance collections. In addition, VA clarified that it may, under limited circumstances, collect from Medicare although generally it may not do so. We changed our report accordingly.

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VA also suggested that our title was misleading because it stated that VA continues to address problems in its collections operations rather than stating that VA is building infrastructure to implement effective collections operations. We believe that our title is accurate because VA continues to address problems that we and others have identified in VA's collections operations. VA has acknowledged such problems in the past, including unidentified insurance for some patients, insufficient documentation for billing, and shortages of coding staff. VA continues to implement the 2001 improvement plan that it developed to address these and other problems. VA's new initiatives also address problems, such as gaps in automated capture of billing data, that have been previously identified.

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As arranged with your office, unless you release its contents earlier, we plan no further distribution of this report until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Veterans Affairs, interested congressional committees, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please call me at (202) 512-7101. James Musselwhite and Terry Hanford also contributed to this report.

Sincerely yours,



Cynthia A. Bascetta  
Director, Health Care—Veterans'  
Health and Benefits Issues

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# Appendix I: Scope and Methodology

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To assess the Department of Veterans Affairs' (VA's) progress with collections in fiscal year 2002, we obtained and examined data on VA's third-party bills and collections. We also interviewed officials in VA headquarters and in three VA health care networks to understand the reasons for the increased collections compared to fiscal year 2001 as well as any operational problems. To provide information on VA's 2001 improvement plan and its emerging new approach to improvements, we reviewed relevant VA documents and interviewed VA officials.

We conducted interviews from April through June 2002 with managers in three networks concerning collections.<sup>1</sup> In addition, we gathered data on third-party bills and collections for fiscal years 2001 and 2002. Our review of the improvement plan's implementation started with its completion status in March 2002 and ended with its status through May 2002, which was the date of VA's last formal report on the plan's status. An official in the Chief Business Office told us in September 2002 that a new status report for the 2001 plan was planned but not yet available. During August through October 2002, we gathered information from officials in the Chief Business Office about additional improvement initiatives.

To better understand the increased collections in fiscal year 2002 and any limitations to those collections, we judgmentally selected three networks for more detailed study. These networks provided different examples of above- and below-average growth in collections, considered separately for inpatient care and outpatient care. (See table 1.) Based on available data at the time of selection, Network 9 (Nashville) had above-average collections increases for both inpatient care and outpatient care bills. Network 2 (Albany) exceeded average collections increases for only outpatient care bills, whereas Network 22 (Long Beach) had above-average collections increases for only inpatient care bills.

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<sup>1</sup>We spoke with revenue managers in the three networks. At the suggestion of the revenue manager in Network 22 (Long Beach), we also spoke with the facility's business manager, who headed the network's collections committee. Moreover, we had limited follow-up discussions during September 2002 with the Network 9 (Nashville) revenue manager.

**Table 1: Percentage Increases in Collections for Networks Selected for Study, October 2000 through February 2001 Compared to October 2001 through February 2002**

	Collections					
	Inpatient care		Outpatient care		Total	
	Percentage increase	Relation to average	Percentage increase	Relation to average	Percentage increase	Relation to average
Systemwide averages	20	Not applicable	54	Not applicable	35	Not applicable
Network 2 (Albany)	3	Below	79	Above	32	Below
Network 9 (Nashville)	43	Above	102	Above	71	Above
Network 22 (Long Beach)	60	Above	34	Below	50	Above

Source: VA Monthly Revenue Office Report: February 2002 Data.

Although we did not verify VA data on collections and bills, we used the data reported by VA’s Revenue Office in its analyses of third-party collections. The data source is VA’s Veterans Health Information Systems and Technology Architecture National Database. This database includes data for collections from various sources—including third-party payments, patient copayments, and proceeds from sharing agreements in which VA sells services to the Department of Defense and other providers.

# Appendix II: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON

December 23, 2002

Ms. Cynthia A. Bascetta  
Director, Health Care—Veterans'  
Health and Benefits Issues  
U. S. General Accounting Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA HEALTH CARE: Third-Party Collections Rising as VA Continues to Address Problems in the Collections Operations*** (GAO-03-145). As the General Accounting Office (GAO) acknowledged, the Veterans Health Administration (VHA) continues to make improvements in increased collections. As GAO reports, VHA's Business Office is developing new initiatives that will further enhance collections. VA suggests that the title is somewhat misleading. Rather than addressing problems in collections operations, VA has actively engaged in building the basic infrastructure (effective management oversight, personnel, information technology systems, processes, etc.) needed to implement and sustain effective collection operations.

VA has one suggested edit to page 1 of the report, third sentence, which states: "VA cannot bill for health care conditions that result from military service, nor is it authorized to collect from Medicare or Medicaid for any conditions." Currently, there are at least two situations in which VA may be reimbursed by the Medicare program: 1) treatment for end-stage renal disease and 2) when VA treats someone believed to be eligible for VA medical care, but turns out to be ineligible for VA care, but covered by Medicare. It is recommended that the word "generally" be inserted before "authorized."

Thank you for the opportunity to comment on your draft report.

Sincerely yours,

A handwritten signature in black ink that reads "Anthony J. Principi".

Anthony J. Principi

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