

**STATEMENT OF
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TO THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
MEDICAL CARE COLLECTION FUND**

SEPTEMBER 20, 2001

Mr. Chairman and Members of the Subcommittee:

The American Legion is pleased to have the opportunity to submit a statement for the record on the progress being made by the Department of Veterans Affairs (VA) to improve its financial management regarding third-party payer collections and contracting out initiatives.

The Balanced Budget Act of 1997, Public Law (P.L.) 105-33, established the Medical Care Collections Fund (MCCF). The MCCF is a depository for third-party insurance, outpatient prescription co-payments and other related medical collections and user fees. The funds collected and deposited into the MCCF may be used only for providing VA medical care and services during any fiscal year and for VA expenses for identification, billing, auditing, legal, and collection of amounts owed the government. As an added note, much to The American Legion's chagrin, the MCCF collections are used as an offset to the appropriations for the medical care budget rather than a supplement. These collections are for the treatment of nonservice-connected medical conditions; therefore, should supplement the annual discretionary appropriations, which covers the cost of medical care authorized to certain veterans in priority categories 1-6. Logically, MCCF is reimbursement for the treatment for which annual discretionary appropriations is not intended. The American Legion continues to adamantly oppose offsetting annual discretionary appropriations by the MCCF recovery..

P.L. 105-33 also established VA's authority to begin billing reasonable charges for the provision of nonservice-connected conditions (implemented by VA in September 1999). Reasonable charges are comparable to charges used in the private sector for the same services in a specific geographic area. Prior to this, VA used cost-based per diem rates for billing insurers. With the authority to bill reasonable charges, VA's collections have increased. To date (FY 2001), VA has collected over \$708 million, an increase of 38 percent over last fiscal year, and predictions is that in FY 2005 to collect \$1.4 billion. Although this sounds like good news, The American Legion notes that this amount could be even higher if VA was granted the authority to bill Medicare directly, either on a fee-for-service basis or under the Medicare+Choice option.

Currently, approximately 70 percent of the health insurance policies reported are Medicare supplement policies. Under current law billing on a fee-for-service basis, VA can expect to collect only 20 percent of the billed amount – the Medicare-eligible veteran is

responsible for paying the remainder of the bill. When a veteran does not have Medicare supplement coverage, the veteran is obligated to pay the entire bill, even if Medicare normally covers the care in the private sector. The amount expected from billing these supplemental policies is much less than if the VA was allowed to bill Medicare directly under the fee-for-service option.

The American Legion fails to understand why VA, unlike Indian Health Services (IHS), cannot participate in Medicare subvention. Eligibility for enrollment or treatment in IHS is based on solely birth. ***Medicare-eligibility is not a condition for enrollment or treatment in IHS.*** Eligibility for enrollment or treatment in VA's health care network is based on honorable military service. ***Medicare-eligibility is not a condition for enrollment or treatment in VA's health care network!*** Therefore, The American Legion fails to understand why VA cannot participate as a health care partner with the Centers for Medicare and Medicaid Services (CMS).

The American Legion strongly advocates CMS allowing Medicare-eligible veterans to exercise their **fee-for-service** or **Medicare+Choice** options. Under the fee-for-service option, VA would only seek reimbursement for the treatment of nonservice-connected conditions for enrolled Medicare-eligible veterans. The American Legion believes VA would readily accept CMS' reimbursement rate for Medicare-eligible patients.

Under the Medicare+Choice option, The American Legion believes that Medicare-eligible veterans would be willing to participate and chose VA as their primary health care provider. Clearly, Medicare+Choice is beneficial to CMS and VA. Medicare+Choice places Medicare-eligible patients into integrated health networks – far more cost effective than the fee-for-service option.

The American Legion reaffirms its opposition to CMS denying Medicare-eligible veterans financial coverage solely because Medicare-eligible veterans choose to enrollment and treatment in the VA health care network, as opposed to seeking care elsewhere. Currently, fewer Medicare beneficiaries cannot exercise their Medicare+Choice options because more and more health care providers are refusing to participate. Yet, The American Legion is urging CMS to allow VA to fill that void. Based on the quality of health care provided by VA, based on CMS' own performance standards, is outstanding. Medicare-eligible veterans and their families would be well served should CMS allowed VA to serve as a Medicare+Choice option.

Billing reasonable charges has created myriad problems for VA as they struggle to streamline the revenue collection process. Itemizing of services on a claim form is labor intensive and to do it efficiently and effectively requires a highly trained staff. Also, VA was not prepared for the scrutiny of the insurance payers to ensure correct billing and compliance with standardized forms and codes. Furthermore, the Veterans Health Administration's (VHA) information system is not configured to handle patient accounting and does not provide the required features and functionality needed to accurately capture data.

In May 2001, Secretary Principi directed the Undersecretary for Health to develop a revenue cycle improvement plan. That plan was delivered in September 2001 and addresses several of the problems confronting VHA for the last four years.

Current Cycle Performance

The revenue cycle effectiveness is measured by specific performance measures. Seven measures have been identified by VHA and compared to private sector performance measures. Private sector benchmarks have been used where applicable.

Percentage of Complete Registrations – Only 58 percent of the medical centers performed in the top tier of performance, which is 100 percent to 80 percent complete registrations, as compared to 82 percent of the private sector.

Percentage of Insurance Policies Verified- VHA performed at a high level of effectiveness for insurance verification, with 94 percent of Veterans Affairs Medical Centers (VAMCs) performing in the top tier of performance, which is 93 percent to 100 percent insurance policies verified. The one drawback to this is that VHA has no national standard for the timeliness of verification. Therefore, VAMC insurance databases may have old verification information in them.

Number of Days for Inpatient and Outpatient Bill Lag – Forty-one medical centers, or 31 percent, performed in the top tier of performance for inpatient services, or 16 to 40 days lag time. Outpatient services were even less than that, with 24 percent of the VAMCs performing in the top tier of performance, or eight and 90 days lag time. Private sector benchmarks for this performance measure are five days for inpatient and six days for outpatient.

Percent of Receivable Dollars Greater than 90 Days Old - This amount represents the monies that have not been paid by the insurance carrier. There is a significant difference in the private sector, at 29 percent and the VHA total at 49 percent. While VHA's percentages have been adjusted due to their inability to bill Medicare, which accounts for 70 percent of their outstanding accounts receivable, the percentage is still very high.

Percentage of Collection Dollars to Billed Dollars- VHA's collection rate is 35 percent.

Collections – VHA has seen an increase in collections with total collections improving by 25 percent in FY 2001.

The American Legion as part of its National Field Service site visits to the VISNs and their medical center components examines data related to MCCF. In particular, the amount of collections and the timeframes to generate billings and make collections. It is not surprising that the feedback mirrors the shortfalls shown in the performance measurements. Data obtained this year was cumulative for FY 2000 and showed that most facilities met or exceeded their collection goals. However, the average times to generate an outpatient bill were quite varied and in numerous cases, they were extremely high. Health Care Systems in VISN 22 reported average times as high as **165 days**, and **183 days**, while medical centers in VISN 9 reported times of **120** and **158 days**. Facilities in VISN 4 reported processing times of 100 and 187 days. In contrast, some medical centers were able to generate bills in 50 to 60 days with the lowest reported

average time in a 20-day range. The combined average time to generate a bill and collect a payment typically approached 6 to 7 months.

It was noted that often there were large amounts (millions of dollars) of past billings in litigation. This appears to be the result of contested bills where carriers are secondary payers to Medicare. Some insurance companies have held off paying Medigap payments of Medicare-eligible veterans because VA is not an authorized Medicare provider and there is no Explanation of Benefits for Medicare on the claims. The American Legion believes resolving this problem could result in collections of about 20 percent of the amounts billed.

In discussing the above data during site visits, VHA facilities have been making efforts to improve their business processes for billing and collection. The American Legion believes VHA is very cognizant of its need to improve. Some facilities experience problems competing for or retaining essential personnel, such as coders. Others are very interested in pursuing remedies, such as electronic billing. However, this can be a resource issue in competing for scarce dollars. VHA also faces challenges in addressing waits and delays for clinical treatment that must be addressed.

Veterans have often shared their perspective on MCCF with The American Legion through their correspondence. Those who write are often frustrated in understanding the process and have difficulty differentiating between third-party reimbursements and co-payments. They are dismayed by the long gaps between treatment times and when they are actually billed. A large percentage of veterans are also concerned about their liability. Continued outreach is needed to better educate veterans on MCCF.

The Revenue Cycle Improvement Plan seeks to overhaul the way VHA does business. The plan lists 24 critical actions that need to be accomplished in the short term. These 24 actions all have a timeline attached to them and the office responsible for ensuring completion of the action. The long-term solutions include consolidation and outsourcing. The American Legion is not opposed to the outsourcing of billing and accounts receivable functions, as well as the patient financial/accounting system. The VA spent approximately \$120 million in FY 2000 on billing, coding, collections, documentation and claims. However, The American Legion would caution that VA's contracting performance in the past has been less than stellar. The American Legion, through its National Field Service site visits, learned that in some cases contracts have been poorly written and have resulted in additional expenses and lack of control.

While generally pleased with the Revenue Cycle Improvement Plan, The American Legion is frustrated at the extension of the process to nearly 2004. We are also somewhat skeptical that the proposed timelines will be adhered to.

The American Legion commends VHA for the progress it has made in some of these areas over the last four years. However, The American Legion remains concerned with the amount of time VHA has taken to reach this point, with yet another extended timeline proposed to fix these problems.

Mr. Chairman, that concludes my statement.