



Office of Inspector General

AUDIT OF THE MEDICAL CARE COST RECOVERY PROGRAM

*By more actively managing MCCR
program activities, VHA can significantly
enhance MCCR recoveries.*

Report No: 8R1-G01-118

Date: July 10, 1998

Office of Inspector General
Washington DC 20420



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Under Secretary for Health (10)

Audit of the Medical Care Cost Recovery Program

1. The purpose of our audit was to determine the Department of Veterans Affairs (VA) success with its cost recovery program by Veterans Integrated Service Network (VISN) and to identify opportunities to enhance Medical Care Cost Recovery (MCCR) Program recoveries. The audit was suggested by the Chairman of the House Committee on Veterans Affairs.
2. In accordance with Title 38, U.S.C. 1710, 1712, 1722A, and 1729 VA collects from third-party health insurers and from certain veterans to offset the cost of providing medical care and medications provided for non-service connected conditions. Each fiscal year the Under Secretary for Health, in consultation with the Office of Management and Budget, establishes a minimum MCCR collection goal for the Veterans Health Administration (VHA). Each of the VISNs and their component medical facilities is assigned a minimum collection goal representing that VISN's/facility's share of the overall national collection goal. Facility goals for FY 1997 were based on previous year collection results, the type of medical services provided (e.g., acute inpatient, long term psychiatry, or outpatient), and patient demographic information such as patient age, compensation or pension disability status, and health insurance coverage. Starting in FY 1998, the Management Decision and Research Center of the VA Health Services Research and Development Service developed a new forecasting model for projecting MCCR revenues. That model projects collections based on workload and demographic trends, insurance coverage, HMO penetration, and other factors.
3. The Balanced Budget Act of 1997 (Public Law 105-33) allows VA to retain MCCR funds collected after June 30, 1997, with each VISN receiving its proportionate share of all such funds collected, to supplement annual appropriations and finance the cost of serving additional veterans. VHA management believes that retention of MCCR collections will provide additional incentive for facility staff to increase recoveries. Between Fiscal Years (FYs) 1987 and 1995, MCCR collections increased from \$23.9 million to \$580.7 million. In FY 1996, collections decreased 4 percent to \$557.2 million from \$580.7 million. Collections in FY 1997 again decreased with total MCCR

collections falling 6.7 percent to \$519.7 million from \$557.2 million in FY 1996. In FY 1997, collections were \$24.4 million lower than the FY 1997 national goal of \$544.1 million.

4. VHA has taken actions to increase MCCR revenues. The Under Secretary for Health has established a goal for VHA to increase the percentage of the operating budget obtained from non-appropriated sources (such as MCCR) to 10 percent of the total by the year 2002. The MCCR Program Office developed, and issued to all VHA facilities, management tools designed to improve MCCR operations (e.g., Preregistration, Autobiller, and Diagnostic Measures). Preregistration involves medical centers contacting patients by telephone and updating their patient demographics database to include health insurance coverage identification. The Autobiller helps ensure that insurance carriers are billed accurately and in a timely manner. Diagnostic Measures allow VHA managers to trend and monitor MCCR program operations. These reports can be used to analyze changes in the MCCR process over a period of time and to evaluate the bottom line results of MCCR operations from patient registration through collection.

5. The audit focused on FY 1997 activities and included analyses of MCCR collections by VISN and an assessment of MCCR policies, procedures, and operations with the objectives of (1) assessing the accuracy of third-party billing, (2) evaluating the effectiveness of MCCR accounts receivable management, and (3) ascertaining the use of management tools developed by the MCCR Program Office designed to improve MCCR operations.

6. Our review of FY 1997 collections showed that 14 of the 22 VISNs did not meet their assigned minimum collection goals. Analysis of questionnaire responses from the 22 VISN Directors, received during the fourth quarter of FY 1997, regarding their role and responsibility in relation to the MCCR program indicated significant differences in the oversight of the MCCR program among VISNs. Responses from the VISN Directors which achieved their collection goals indicated a more active oversight of MCCR activities. Those VISNs which did not achieve FY 1997 goals indicated their oversight generally was limited to review of MCCR billing and collection reports submitted by the facilities.

7. Our review of FY 1997 patient discharges identified additional cases which should have been billed. Based on our sample results, we estimate FY 1997 collections could have increased \$26.7 million from 12,288 patients. We also reviewed MCCR third-party accounts receivable and found that VHA staff did not telephone insurance carriers as required by VA policy in 65 percent of delinquent accounts. We determined that collections were enhanced when unpaid debts were pursued by telephone contact with insurance carriers. We project that VHA could increase collections by \$56.5 million, if delinquent accounts receivable were pursued more aggressively by contacting insurance carriers. Our sample results also showed that 25 percent of the delinquent accounts had been referred to Regional Counsels for enforced collection, however, no recoveries had

been made on these receivables. Improved communication and coordination between VHA facilities and Regional Counsels would further enhance MCCR revenues.

8. We also found VHA's billing and collection operation did not compare well with private sector hospitals. We found it took an average of 48 days for VHA to issue bills to third-party payers. By comparison, the Hospital Accounts Receivable Analysis (HARA) report, a national private sector benchmark for hospital receivables, reported in September 1997, it took hospitals in their study an average of only 9 days to issue a bill. We also found 52 percent of VHA's receivables as of September 30, 1997, were greater than 90 days old, while the September 1997 HARA report disclosed that for private sector hospitals only 28 percent of receivables were over 90 days old. VHA can enhance collections and improve billing results by developing and adopting private sector benchmarks to monitor billing practices and accounts receivable management.

9. VHA had not established performance standards for facility staff conducting patient registration, billing, collection, and utilization review to monitor performance results. Our analysis of questionnaires received from 149 VHA facilities indicate that management tools developed by the MCCR Program Office (Preregistration, Autobiller, and Diagnostic Measures) can enhance identification of insurance policies and ensure billing and collection follow-up is accomplished. However, use of the management tools was not mandated and as a result we found that as of September 30, 1997, many facilities had not used these management tools. Establishing performance standards, using MCCR management tools, and taking management action to reduce performance gaps will also enhance collections.

10. We also identified an additional area where, in our opinion, management action can help increase recoveries. During our review we did not find any examples of best practices of how to promote the MCCR program. Facility staff and patients were generally not provided information on how MCCR recoveries benefit each facility's ability to provide medical services to patients or the detrimental consequences if MCCR funds were not available. We believe that by providing staff, patients, and Veterans Service Organizations this information (i.e., better promoting the benefits of the MCCR program), VHA could increase support for the MCCR program and further increase collections. For example, our review found that only 9.4 percent of the inpatient episodes of care provided during FY 1997 were identified by VHA staff as billable to an insurance carrier. However both a VHA study and a study by the Agency for Health Care Policy and Research indicated that up to 40 percent of VA's patients have health care insurance. Better public relations should encourage more veterans to voluntarily provide health insurance information.

11. We concluded VHA can enhance MCCR recoveries by over \$83 million by requiring VISN Directors to more actively manage MCCR program activities. Additionally, facilities should be required to (a) use management tools, (b) better manage and more aggressively pursue collection of delinquent accounts receivable, (c) establish performance standards for facility staff involved in all phases of MCCR activities, and (d) monitor performance results and take action to improve performance gaps.

12. We recommend that you improve MCCR program activities by:

a) requiring the Chief Network Officer to ensure that VISN Directors more actively manage network MCCR program activities to include (1) developing performance measures to improve the timeliness and accuracy of billings, and the management and collection of accounts receivable, (2) monitoring the performance results, (3) taking corrective action to improve performance gaps, and (4) enhancing communication and coordination with Regional Counsels in an effort to improve recoveries on accounts receivable referred for collection,

b) mandating the use of management tools (Preregistration, Autobiller, and Diagnostic Measures) at all facilities to better ensure veterans' health insurance carriers are identified, appropriate billing is accomplished in a timely manner, and collection of accounts receivable is pursued effectively,

c) establishing performance standards for clinical and administrative staff involved in all phases of MCCR activities to include patient registration, billing, collection, and utilization review and requiring VHA managers to monitor performance results and take action to improve performance gaps, and

d) better promoting the importance of the MCCR program by ensuring VHA facility staff, patients, and Veterans Service Organizations have access to information demonstrating (1) how MCCR recoveries benefited each facility's ability to provide medical services to patients and (2) the detrimental effect on operations if MCCR funds were not available to supplement facility budgets.

13. You concurred with the findings, recommendations, and estimated monetary benefits. You also provided an acceptable implementation plan and we consider all issues resolved. However, we will follow up on the implementation of planned corrective actions.

For the Assistant Inspector General for Auditing,

(Original signed by:)

THOMAS L. CARGILL, JR.

Director, Bedford Audit Operations Division

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RESULTS AND RECOMMENDATION

By More Actively Managing the MCCR Program Activities, VISN Directors Can Enhance MCCR Recoveries

Our review of the Veterans Health Administration (VHA) Medical Care Cost Recovery (MCCR) Program showed that VHA can enhance MCCR recoveries by requiring Veterans Integrated Service Network (VISN) Directors to more actively manage MCCR program activities. Our review of Fiscal Year (FY) 1997 MCCR operations identified the following opportunities to enhance MCCR recoveries.

- We found 14 of 22 VISNs did not collect their assigned FY 1997 minimum collection goals. Based on collection results and the questionnaire responses from 22 VISNs, we concluded that more active management by VISN Directors could enhance MCCR collections.
- Review of a 350 case statistical sample of 614,419 FY 1997 patient discharges identified an additional 7 cases, valued at \$46,130, which should have been billed. Based on our sample results, we estimate FY 1997 collections could have been increased by \$26.7 million, if VHA strengthened billing practices and procedures.
- Review of a stratified statistical sample of 353 MCCR third-party accounts receivable from a universe of 861,670 accounts, valued at approximately \$544 million, showed that VHA staff did not follow-up on receivables as required by Department of Veterans Affairs (VA) policy in 229 (65 percent) of the cases reviewed. We project that VHA could increase collections by \$56.5 million by more aggressively pursuing collection of delinquent accounts receivable.
- Analysis of questionnaires received from 149 VHA facilities indicate that management tools developed by the MCCR Program Office (Preregistration, Autobiller, and Diagnostic Measures) can enhance identification of insurance policies and ensure billing and collection follow-up are accomplished. However, use of the management tools was not mandated and as a result we found that as of September 30, 1997, many facilities had not used these management tools.
- VHA had not established performance standards for facility clinical and administrative staff conducting patient registration, billing, collection, and utilization review to monitor performance results.

We concluded that VHA can enhance MCCR recoveries by requiring hospital management to focus more closely on program performance to include developing and monitoring program performance measures, requiring the use of MCCR management tools, enhancing the management and collection of accounts receivable, and establishing

and monitoring performance standards for all clinical and administrative staff involved in the MCCR process.

Background

For FY 1997, the Under Secretary for Health established a minimum MCCR collection goal of \$544.1 million for VHA. Each of the VISNs and their component medical facilities was assigned a minimum collection goal representing that VISN's/facility's share of the overall national collection goal. Facility goals were based on previous year collection results, the type of medical services provided (e.g., acute inpatient, long term psychiatry or outpatient), and patient demographic information such as patient age, compensation or pension disability status, and health insurance coverage. Total FY 1997 collections were \$519.7 million, or \$24.4 million less than the \$544.1 million goal. The Balanced Budget Act of 1997 (Public Law 105-33) allows VA to retain MCCR funds collected after June 30, 1997, with each VISN receiving its proportionate share of all such funds collected, to supplement annual appropriations and finance the cost of serving additional veterans. VHA management believes that retention of MCCR collections will provide additional incentive for facility staff to increase recoveries.

More Active VISN Management Improved Collection Results

We found 14 of 22 VISNs did not collect their assigned FY 1997 minimum collection goals. If the 14 VISNs had collected their minimum goal amounts, the national FY 1997 collections would have totaled \$555.6 million, or about \$11.5 million over the \$544.1 million goal.

Analysis of questionnaire responses from the 22 VISN Directors, received during the fourth quarter of FY 1997, regarding their role and responsibility in relation to the MCCR program indicated significant differences in the oversight of the MCCR program among VISNs. Responses from the Directors of VISNs which achieved collection goals indicated a more active oversight of MCCR activities. Directors for those VISNs which did not achieve FY 1997 goals indicated their oversight generally was limited to review of MCCR billing and collection reports submitted by the facilities. Based on collection results and the questionnaire responses from 22 VISNs, we concluded that more active management by VISN Directors could enhance MCCR collections.

(See Appendix IV on page 17 for FY 1997 Collections by VISN.)

Actions to Increase Collections

VHA management has established goals and provided management tools to field facilities to increase MCCR revenues. The Under Secretary for Health has established a goal for VHA to increase the percentage of the operating budget obtained from non-appropriated sources (such as MCCR) to 10 percent of the total by the year 2002. The MCCR Program Office developed, and issued to all VHA facilities, management tools designed to improve MCCR operations (e.g., Preregistration, Autobiller, and Diagnostic Measures). Preregistration involves medical centers contacting patients by telephone and updating their patient demographics database to include health insurance coverage identification. The Autobiller helps ensure that insurance carriers are billed accurately and in a timely manner. Diagnostic Measure reports allow VHA managers to trend and monitor MCCR program operations. These reports can be used to analyze changes in the MCCR process over a period of time and to evaluate the bottom line results of MCCR operations from patient registration through collection.

Opportunities to Further Enhance Revenues

We assessed FY 1997 MCCR activities and operations and identified opportunities for VHA to enhance MCCR collections by (1) billing health insurance carriers, (2) pursuing collection of delinquent accounts receivable, and (3) using management tools to improve operations.

Billing Health Insurance Carriers

VA Manual MP-4, Part VIII authorizes VA to collect from third-party health insurers to offset the cost of medical care furnished to a veteran for the treatment of a nonservice-connected condition. VHA medical facilities generate bills to notify insurance carriers of accounts receivable established for patients discharged after receiving VA provided reimbursable medical care.

We reviewed a statistical sample of 350 cases selected from 614,419 patients discharged from inpatient care by VHA during the period October 1, 1996 to July 31, 1997. We found that only 33 (9.4 percent) of the 350 cases had been billed by the local facilities. We also identified, and VHA facilities have agreed and billed, an additional 7 cases with billings totaling \$46,130 which should have been billed. Use of the management tools could have ensured these cases were billed. For example:

- A veteran with health insurance received inpatient care from April 15, 1997 to April 24, 1997. Facility staff did not bill the veteran's insurance carrier until audit inquiry. The carrier was billed \$13,968 on October 23, 1997 and \$11,956 was collected on November 18, 1997.

Based on our sample results, we project that the universe of 614,419 FY 1997 patient discharges contained \$80.9 million in unbilled care for 12,288 patients. Using the national MCCR collection rate of 33 percent, we estimate that FY 1997 collections could have increased \$26.7 million.

(See Appendix III on page 14 for a description of our sampling plan and results.)

Pursuing Collection of Accounts Receivable

VA Manual MP-4, Part VIII provides that VHA facility staff follow up on delinquent accounts receivable. A second notice is sent 45 days after issuance of the initial claim and, if no response is received, a third notice is sent 30 days later. At the time the third notice is sent, telephone follow-up should be made with the third-party payer. The telephone follow-up should be documented to include at a minimum, the name and telephone number of person contacted, date of contact, and a brief summary of the conversation. If there is no response from the third-party payer within 30 days after the second follow-up, the case is to be referred to Regional Counsel for appropriate collection action.

To determine the effectiveness of MCCR debt management, we conducted a stratified statistical sample of 353 MCCR third-party accounts receivable. We selected this statistical sample from a universe of 861,670 accounts valued at approximately \$544 million as of September 30, 1997. The results of our sample showed that 229 or 65 percent of the delinquent debts reviewed were not followed up by telephone as required by VA policy.

We found that revenues could be enhanced when facilities contact (telephone) insurance carriers to follow up on delinquent debts. We determined that recoveries were enhanced when collections were pursued by telephone contact with insurance carriers. For example:

-An insurance carrier was billed May 1, 1997 for 12 days of general medical care totaling \$12,552. VAMC staff followed up by contacting the carrier on August 26, 1997 and were told that the bill had not been received. The bill was resubmitted by certified mail on September 3, 1997. Additional telephone follow up was done on September 11 and 30 to ensure the payment was in process. The \$12,552 bill was paid in full on October 15, 1997. Without telephone follow-up it is unlikely VA would have received any payment on this bill.

Our analysis of sample results showed increased collections when facilities telephone insurance carriers when the debt is delinquent. We project that VHA could increase collections by \$56.5 million through more aggressively pursuing collection of delinquent accounts receivable by contacting insurance carriers.

(See Appendix III on page 14 for a description of our sampling plan and results.)

Effective Utilization Review Can Enhance Collections

We found only 25 (7 percent) of the 353 cases in our accounts receivable sample had been referred to Utilization Review (UR) Nurses for appeal of the insurance carrier's denial of payment. We found that an effective UR appeal program can significantly impact collections.

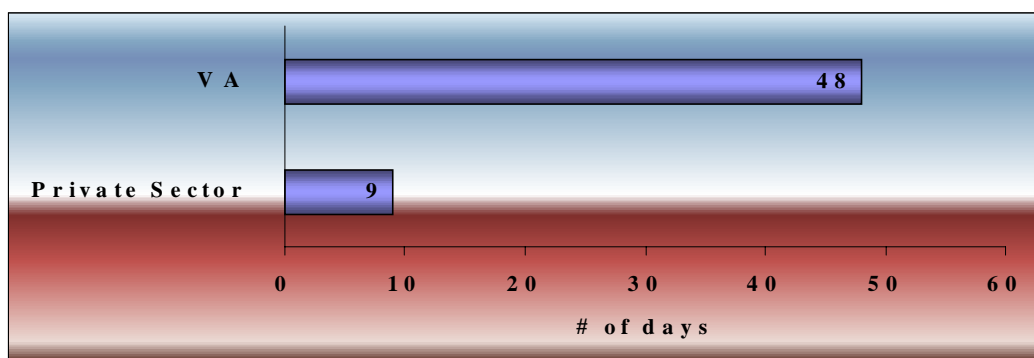
We visited the Central Texas Veterans Health Care System (VAMCs Temple, Waco, and Marlin, TX.) to review the collections accomplished by the UR Nurse on billings for which payment had been denied by health insurance carriers. We found that during the four-year period 1994-1997, the UR nurse had collected over \$1,089,000 (52 percent) of billings totaling \$2,092,000 by aggressively appealing/following-up on denied claims. The success experienced by the UR Nurse can be attributed to aggressive follow-up combined with her ability to provide additional clinical information to support claims, and knowledge of insurance coverage of major insurance carriers.

Effective Communication With Regional Counsel Could Further Enhance Collection of Delinquent Accounts

Our sample results also showed that 89 accounts, valued at approximately \$1.7 million, had been referred to Regional Counsel for enforced collection. The dates of referral for these accounts ranged from November 1991 to November 1997. As of November 30, 1997, VHA facilities had not received any payments from insurance carriers on the 89 accounts. Our review found minimal follow-up communication between VHA and Regional Counsel regarding the collection status of the referred accounts. We also found through an analysis of questionnaire responses that 49 of 149 facilities indicated communication between VHA and Regional Counsel could be enhanced. Based on our sample results, we estimate that \$176.3 million (32 percent) of the \$544 million third-party accounts receivable universe as of September 30, 1997 had been referred to Regional Counsel and that collection results had been minimal. We understand a nationwide debt reconciliation project between VHA facilities and Regional Counsels has been ongoing since April 30, 1997 to improve accountability. We believe that VISN Directors need to ensure that VHA facilities and Regional Counsels develop an effective working relationship in an effort to enhance collection results on referred receivables. As of April 8, 1998, management indicated that all but three VHA facilities have reconciled third-party referrals with Regional Counsel. Successful reconciliation of referred debts is a key step in improving communication and coordination between VHA facilities and Regional Counsels. VISN Directors, could improve recoveries by following up on accounts receivable referred to Regional Counsels for collection and by enhancing communication and coordination with Regional Counsels.

Comparison with Private Sector Hospitals

We found VHA's billing and collection operation did not compare well with private sector hospitals. We found it took an average of 48 days for VA to issue bills to third-party payers for cases reviewed in FY 1997. By comparison, the Hospital Accounts Receivable Analysis (HARA) report, a national private sector benchmark for hospital receivables reported in September 1997 it took hospitals in their study an average of only 9 days to issue a bill. The bar graph below illustrates this comparison of time taken to issue a bill.



We also found about 52 percent of VHA's third-party receivables as of September 30, 1997 were greater than 90 days old, while the September 1997 HARA report disclosed that for private sector hospitals only 28 percent of receivables were over 90 days old. The table below illustrates our aging of the third-party accounts as of September 30, 1997:

Day Range	Count	Percent/Count	Amount
1-30	238,446	27.7	\$94,824,182
31-60	107,227	12.5	58,879,030
61-90	67,584	7.8	40,248,467
91>	<u>448,413</u>	<u>52.0</u>	<u>350,201,284</u>
Total	<u>861,670</u>	<u>100.0</u>	<u>\$544,152,963</u>

VHA can enhance collections and improve billing results by developing and adopting private sector benchmarks to monitor billing practices and accounts receivable management.

Use of Management Tools

Analysis of questionnaires from 145 of the 149 VHA facilities indicated that identifying and properly billing insurance carriers is a major challenge. Our analysis of questionnaires also indicate that management tools developed by the MCCR Program Office (Preregistration, Autobiller, and Diagnostic Measures) can enhance identification

of insurance policies and ensure billing and collection follow-up is accomplished. However, use of the management tools was not mandated, and as a result we found that as of September 30, 1997, many facilities had not used these management tools.

- 88 (59 percent) of 149 facilities were not routinely using Preregistration. Use of Preregistration would involve medical centers contacting patients by telephone and updating their patient demographics database to include health insurance coverage. According to MCCR Program Office records, during FY 1996 10 VHA facilities tested the preregistration process. The 10 facilities made 68,412 telephone contacts with veterans and identified 11,945 (17.5 percent of 68,412 calls) billable insurance policies. Based on actual collections of \$6,427,475 directly resulting from the preregistration calls, the economic benefit of using preregistration was \$94 per call made. The MCCR Program Office has estimated that revenues could be enhanced by as much as \$100 million through a nationwide implementation of Preregistration.
- 21 (14 percent) of 149 facilities were not routinely using Autobiller. Use of the Autobiller would ensure that insurance carriers are automatically billed in a timely manner for billable episodes of care based on the patient insurance file. At one medical facility the number of bills issued to insurance carriers totaled 23,097 in FY 1995 (prior to using the Autobiller). The facility used the Autobiller during the entire period of FY 1997 and issued 39,282 bills to insurance carriers, an increase of 70 percent. Inpatient bills were issued an average of 15 days from date of discharge.
- 50 (34 percent) of 149 facilities were not routinely using Diagnostic Measures. Use of Diagnostic Measure reports would allow VHA personnel to trend MCCR program operations. These reports can be used to analyze changes in the MCCR process over a period of time and to evaluate the bottom line results of MCCR operations from registration through collection.

Establishing Performance Standards and Using Management Tools

VHA had not established performance standards for facility clinical and administrative staff conducting patient registration, billing, collection, and utilization review to monitor performance results. The Diagnostic Measures tools developed by the MCCR Program Office could be used by managers to:

- ascertain actual facility/staff performance in all phases of the MCCR Program,
- help establish specific goals and related performance standards to better identify veterans with insurance, and improve billing accuracy and timeliness, utilization review results, and accounts receivable management, and
- monitor facility/staff performance to recognize best practices and identify and correct performance gaps.

Questionnaires received from 95 of 149 facilities, indicated that MCCR staff felt obtaining information from clinicians was a challenge to timely and accurate billing. Use of Diagnostic Measures can help management improve operations. For example, a utilization review Diagnostic Measure summary report provides facilities with various statistics on denials by insurance carriers. Data elements captured by this report include the number of admission or continued stay denials, the number of days denied by insurance carriers and the responsible clinician. Analyses of this information could identify opportunities to increase MCCR recoveries by involving clinicians in providing clinical justification to insurance carriers for treatment furnished. Alternatively, management could use this information to identify clinical staff who may need education on the appropriateness of admission/continued stay.

Establishing performance standards, using MCCR management tools to gather and monitor data, and taking management action to reduce performance gaps will enhance collections.

Improving the Promotion of the MCCR Program

We also identified an additional area where, in our opinion, management action can help increase recoveries. During our review we did not find any examples of best practices of how to promote the MCCR program. Facility staff and veterans were generally not provided information on how MCCR recoveries benefit each facility's ability to provide medical services to patients or the detrimental consequences if MCCR funds were not available. We believe that by providing staff and veterans, to include Veteran Service Organizations, this information (i.e., better promoting the benefits of the MCCR program), VHA could increase support for the MCCR program and further increase collections. For example our review found that only 9.4 percent of the inpatient episodes of care provided during FY 1997 were identified by VHA staff as billable to an insurance carrier.¹ However both a VHA study and a study by the Agency for Health Care Policy and Research indicated that up to 40 percent of VA's patients have health care insurance. Better public relations should encourage more veterans to voluntarily provide health insurance information and further help enhance revenues from non-appropriated funds.

¹ Preregistration tests at 10 VHA facilities identified billable policies in 17.5 percent of veterans contacted.

Conclusion

We concluded VHA can enhance MCCR recoveries by over \$83 million by requiring VISN Directors to more actively manage MCCR program activities. Additionally, facilities should be required to (a) use management tools, (b) better manage and more aggressively pursue collection of delinquent accounts receivable, (c) establish performance standards for facility staff involved in all phases of MCCR activities, and (d) monitor performance results and take action to improve performance gaps.

Recommendation

We recommend that you improve MCCR program activities by:

- a. Requiring the Chief Network Officer to ensure that VISN Directors more actively manage network MCCR program activities to include (1) developing performance measures to improve the timeliness and accuracy of billings, and the management and collection of accounts receivable, (2) monitoring the performance results, (3) taking corrective action to improve performance gaps, and (4) enhancing communication and coordination with Regional Counsel in an effort to improve recoveries on accounts receivable referred for collection.
- b. Mandating the use of management tools (Preregistration, Autobiller, and Diagnostic Measures) at all facilities to better ensure veterans' health insurance carriers are identified, appropriate billing is accomplished in a timely manner, and collection of accounts receivable is pursued effectively.
- c. Establishing performance standards for administrative and clinical staff involved in all phases of MCCR activities to include patient registration, billing, collection, and utilization review and requiring VHA managers to monitor performance results and take action to improve performance gaps.
- d. Better promoting the importance of the MCCR program by ensuring VHA facility staff, patients, and Veterans Service Organizations have access to information demonstrating (1) how MCCR recoveries benefited each facility's ability to provide medical services to patients and (2) the detrimental effect on operations if MCCR funds were not available to supplement facility budgets.

(Monetary impact associated with the recommendation is shown in Appendix V, page 18.)

Under Secretary for Health Comments

The Under Secretary for Health concurred with the findings, recommendations, and estimated monetary impact.

Implementation Plan

The Under Secretary provided an implementation plan which addressed each recommendation and included estimated target completion dates for taking corrective action. *(See Appendix VI on pages 19-23 for the full text of the Under Secretary's comments.)*

Office of Inspector General Comments

The implementation plan is acceptable and we consider all issues resolved. However, we will follow up on the implementation of planned corrective actions.

BACKGROUND

In accordance with Title 38, U.S.C. 1710, 1712, 1722A, and 1729 the Department of Veterans Affairs (VA) collects from third-party health insurers and from certain veterans to offset the cost of furnishing medical care and medications provided for non-service connected conditions. The mission of the Medical Care Cost Recovery (MCCR) Program is to maximize the recovery of funds due VA for the provision of health care services to veterans, dependents and others using the Veterans Health Administration (VHA) system. Under provisions of MCCR legislation, MCCR is authorized to;

- Submit claims to and recover payments from veterans' third-party health insurance carriers for treatment of nonservice-connected conditions,
- Recover copayments from certain veterans for treatment of nonservice-connected conditions, and
- Recover copayments for medications from certain veterans for treatment of nonservice-connected conditions.

For Fiscal Year (FY) 1997, the Under Secretary for Health, established a minimum MCCR collection goal of \$544.1 million for VHA. Each Veterans Integrated Service Network (VISN), and its component medical facilities, was assigned a minimum collection goal representing that VISN's/facility's share of the overall national collection goal. Facility goals for FY 1997 were based on previous year collection results, the type of medical services provided (e.g., acute inpatient, long term psychiatry or outpatient), and patient demographic information such as patient age, compensation or pension disability status, and health insurance coverage. Starting in FY 1998, the Management Decision and Research Center of the VA Health Services Research and Development Service developed a new forecasting model for projecting MCCR revenues. That model projects collections based on workload and demographic trends, insurance coverage, HMO penetration, and other factors.

Between FYs 1987 and 1995, MCCR collections increased from \$23.9 million to \$580.7 million. In FY 1996 collections decreased 4 percent to \$557.2 million from \$580.7 million. Collections in FY 1997 again decreased with total MCCR collections falling 6.7 percent to \$519.7 million from \$557.2 million in FY 1996. In FY 1997, collections were \$24.4 million lower than the FY 1997 national goal of \$544.1 million.

OBJECTIVE, SCOPE AND METHODOLOGY**Objective**

The purpose of our audit was to determine the Department of Veterans Affairs (VA) success with its cost recovery program by Veterans Integrated Service Network (VISN) and to identify opportunities to enhance Medical Care Cost Recovery (MCCR) Program recoveries. The audit was suggested by the Chairman of the House Committee on Veterans Affairs.

Scope and Methodology

The audit focused on FY 1997 activities and included analyses of MCCR collections by VISN and an assessment of MCCR policies, procedures, and operations with the objectives of (1) assessing the accuracy of third-party billing, (2) evaluating the effectiveness of MCCR accounts receivable management, and (3) ascertaining the use of management tools developed by the MCCR Program Office designed to improve MCCR operations (Preregistration, Autobiller, and Diagnostic Measures). To accomplish our objectives we:

- Reviewed and evaluated national MCCR program policies and operational reports.
- Analyzed questionnaire responses from 22 VISN Directors to ascertain their role and responsibility for MCCR.
- Reviewed a statistical sample of patients discharged during the period from October 1, 1996 to July 31, 1997, to determine whether health insurers were properly billed for care provided.
- Reviewed a statistical sample of third-party MCCR receivables as of September 30, 1997, to evaluate the effectiveness of debt management.
- Analyzed questionnaire responses from 149 Veterans Health Administration (VHA) medical facilities regarding local MCCR operations to evaluate use of management tools developed by the MCCR Program Office (e.g., Preregistration, Autobiller, and Diagnostic Measures).
- Conducted site visits to three VISN offices and to five VHA medical facilities.

- Discussed the scope, audit process, findings and proposed recommendations at various stages of the audit with VHA program officials.

The audit was conducted in accordance with generally accepted government auditing standards and included such tests of procedures and records, as we considered necessary under the circumstances.

DETAILS OF REVIEW

Sampling Plans and Results

Our audit of the Medical Care Cost Recovery (MCCR) Program involved sampling plans for billing inpatient care and managing accounts receivable.

A. Billing Inpatient Care

Audit Universe

The audit universe consisted of 614,419 discharges from inpatient care by all Veterans Health Administration (VHA) facilities according to the Patient Treatment File (PTF) for the period October 1, 1996 to July 31, 1997.

Sample Design

The purpose of our case selection was to determine if VHA appropriately billed for inpatient care provided. The sample was based on an attribute sampling design at a 95 percent confidence level. We randomly sampled 350 cases from the 614,419 PTF universe.

Sample Results

Projected Cases of Unbilled Care

Our sample of 350 episodes of inpatient care showed that only 33 or (9.4 percent) had been billed. Our review identified 7 additional episodes of care that should have been billed at a cost of \$46,130. Based on our sample results, we project that the universe of 614,419 patient discharges contained 12,288 cases with unbilled care. This projection has a confidence level of 95 percent and a confidence interval +/- 9,010, resulting in a lower limit of 3,279 and an upper limit of 21,298. Based on the average unbilled amount of \$6,590 per case (\$46,130/7), we estimate that the 12,288 cases had \$80,980,424 in unbilled care. Based on the Fiscal Year 1997 MCCR collection rate of 33 percent, we estimate that VHA could have increased collections \$26,723,540.

Population Size	Sample Size	Number/% Of Billable Cases	Projected Number of Cases	Amount Billable Care	National Collection Rate	Projected Collections
641,419	350	7 (2%)	12,288	\$80,980,424	33%	\$26,723,540

B. Managing Accounts Receivable

Audit Universe

The audit universe consisted of 861,670 third-party accounts receivable with balances of \$10 or more. The 861,670 accounts receivable balances totaled approximately \$544 million and were extracted from VHA's Decentralized Hospital Computer Program files as of September 30, 1997.

Sample Design

The purpose of our account selection was to evaluate collection activity of delinquent third-party accounts receivable. The sample consisted of 353 accounts receivable of the 861,670 accounts receivable universe and was based on a stratified sampling design at the 95 percent confidence level. We stratified the sample into the following dollar range strata:

- \$10.00 to \$999.99,
- \$1,000.00 to \$7,999.99,
- \$8,000.00 to \$24,999.99, and
- \$25,000 and greater.

Sample Results

Comparison of Collection Results With and Without Telephone Contact

In 124 of the 353 accounts sampled, VHA staff pursued collections by telephone contact with insurance carriers. Collections on these accounts totaled \$207,457. By contrast, we found that in the remaining 229 sampled accounts, VHA staff did not pursue collections by telephone contact with insurance carriers. Collections on these accounts totaled \$165,410, or an average of about 43 percent less per account. Our analysis showed an additional economic benefit when facilities contact (telephone) insurance carriers when the debt is delinquent as required by VA policy.

<u>Collections With Telephone Contact</u>			<u>Collections Without Telephone Contact</u>			<u>Difference In Collection</u>
(1)	(2)	(3)	(4)	(5)	(6)	(3) – (6)
Sample		Avg.	Sample		Avg.	Additional
<u>Count</u>	<u>Collections</u>	<u>Collection</u>	<u>Count</u>	<u>Collections</u>	<u>Collection</u>	<u>Benefit</u>
22	\$1,670	\$75.91	66	\$2,595	\$39.32	\$36.59
14	\$23,340	\$1,667.14	29	\$15,797	\$544.72	\$1,122.42
40	\$70,330	\$1,758.25	80	\$52,316	\$653.95	\$1,104.30
48	\$112,117	\$2,335.77	54	\$94,702	\$1,753.74	\$582.03
<u>124</u>	<u>\$207,457</u>	\$1,673.04	<u>229</u>	<u>\$165,410</u>	\$722.31	

Projected Additional Collections by Telephone Contact

We found, in 229 of the 353 accounts sampled, VHA staff did not telephone insurance carriers as required by VA policy. Projecting our sample results to the universe of accounts, we estimate that VHA staff did not contact by telephone insurance carriers in 642,159 accounts. Our projection has a rate of occurrence of 74.525 percent, with a confidence interval of +/- 73,825, resulting in a lower limit of 568,334 accounts and an upper limit of 715,985 accounts. We applied the additional economic benefit resulting when collections are pursued by telephone contact with the insurance carrier to the 642,159 accounts by strata. The projection analysis is as follows:

<u>Population Size</u>	<u>Sample Size</u>	<u>Number Without Telephone Contact</u>	<u>Percent Point Estimate</u>	<u>Number Point Estimate</u>	<u>Additional Benefit</u>	<u>Projected Collections</u>
814,463	88	66	75.000	610,847	\$36.59	\$22,350,892
31,926	43	29	67.442	21,531	\$1,122.42	\$24,166,825
12,320	120	80	66.667	8,213	\$1,104.30	\$9,069,616
<u>2,961</u>	<u>102</u>	<u>54</u>	<u>52.941</u>	<u>1,568</u>	<u>\$582.03</u>	<u>\$912,623</u>
<u>861,670</u>	<u>353</u>	<u>229</u>	<u>74.525</u>	<u>642,159</u>		<u>\$56,499,956</u>

**FISCAL YEAR 1997 COLLECTIONS BY
VETERANS INTEGRATED SERVICE NETWORK (VISN)**

<u>VISN</u>	<u>FY 1997 COLLECTIONS</u>	<u>FY 1997 GOALS</u>	<u>ACHIEVED GOAL</u>	<u>PERCENT OF MINIMUM GOAL</u>
VISN 1	\$31,761,123	\$32,394,216	NO	98.05%
VISN 2	\$19,426,754	\$17,241,651	YES	112.67%
VISN 3	\$35,727,271	\$35,178,748	YES	101.56%
VISN 4	\$30,524,911	\$29,324,135	YES	104.09%
VISN 5	\$17,604,679	\$18,822,368	NO	93.53%
VISN 6	\$32,702,467	\$36,508,578	NO	89.57%
VISN 7	\$30,125,106	\$32,140,304	NO	93.73%
VISN 8	\$29,411,175	\$31,582,878	NO	93.12%
VISN 9	\$28,226,734	\$27,514,118	YES	102.59%
VISN 10	\$18,874,643	\$19,304,223	NO	97.77%
VISN 11	\$22,653,705	\$21,488,705	YES	105.42%
VISN 12	\$32,100,968	\$31,351,032	YES	102.39%
VISN 13	\$17,318,339	\$14,859,090	YES	116.55%
VISN 14	\$11,560,745	\$13,087,012	NO	88.34%
VISN 15	\$20,176,295	\$21,416,915	NO	94.21%
VISN 16	\$41,212,420	\$49,994,798	NO	82.43%
VISN 17	\$23,420,829	\$24,899,320	NO	94.06%
VISN 18	\$20,218,584	\$17,757,159	YES	113.86%
VISN 19	\$13,951,067	\$15,366,430	NO	90.79%
VISN 20	\$18,251,781	\$20,781,983	NO	87.83%
VISN 21	\$10,910,914	\$12,242,023	NO	89.13%
VISN 22	<u>\$13,573,690</u>	<u>\$20,872,456</u>	NO	65.03%
TOTALS	<u>\$519,734,200</u>	<u>\$544,128,142</u>	NO	95.52%

MONETARY IMPACT IN ACCORDANCE WITH IG ACT
AMENDMENTS

REPORT TITLE: **Audit of the Medical Care Cost Recovery Program**

PROJECT NUMBER: **7R1-466**

<u>Recommendation</u>	<u>Category / Explanation of Benefits</u>	<u>Recommended Better Use of Funds</u>
a-d	Better Use of Funds: Utilizing management tools developed by the MCCR Program Office including identifying and billing veterans' insurance carriers would increase collections.	\$26,723,540
a-d	Better Use of Funds: Aggressively pursuing collection of delinquent accounts receivable by contacting insurance carriers would increase collections.	<u>56,499,956</u>
	Total Recommended Better Use of Funds	<u>\$83,223,496</u>

NOTE: Recommendations a through d address the recurring nature of actively managing MCCR program activities. Therefore, it is reasonable to project that over the remaining 5 years of the VA Strategic Plan, Fiscal Year (FY) 1998-2003, \$416 million in increased collections (\$83.2 x 5 years) will occur by better identifying billable episodes of care and more aggressively pursuing collection of third-party delinquent accounts receivable.

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JUNE 26, 1998

**Department of
Veterans Affairs**

Memorandum

Date: June 26, 1998

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report, *Audit of the Medical Care Cost Recovery (MCCR) Program*

To: Assistant Inspector General for Auditing (52)

1. The appropriate program offices have reviewed the above referenced report, and we generally concur with your findings and recommendations. Although we have taken a number of actions to increase revenues from recoveries, some of which you point out in your report, we agree that a continuing, more focused effort is required if VISNs are going to meet the established goal of increasing the percentage of their operating budgets from non-appropriated resources by 2002. A more detailed discussion of our efforts to increase recoveries is found in the attached action plan.

2. Although we concur with the report, we would like to clarify some of the information presented. Page 1 of the Memorandum to the Under Secretary and pages 2 and 10 of the report contain the statement, "Facility goals are based on previous year collection results, the type of medical services provided (e.g., acute inpatient, long term psychiatry, or outpatient), and patient demographic information such as patient age, compensation or pension disability status, and health insurance coverage." This statement is accurate for fiscal years prior to 1998; however, the methodology for developing facility goals has changed. Your discussion should clarify the change and should also include the following statement. The Management Decision and Research Center (MDRC) of the VA Health Services Research and Development Service (HSR&D) has developed a new forecasting model for the Medical Care Cost Fund (MCCF) (formerly MCCR) revenue that projects collections based on workload and demographic trends, insurance coverage, HMO penetration and other factors."

3. In the better use of funds category, the estimate of \$83.2 million through the better use of management tools and aggressively pursuing delinquent accounts seems reasonable.

4. Thank you for the opportunity to review the report. If you have any questions, please contact Paul C. Gibert, Jr., Director, Management Review and Administration Service (105E), Office of Policy and Planning, at 273-8355.

(Original signed by)

Kenneth W. Kizer, M.D., M.P.H.

Attachment

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JUNE 26, 1998

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: *Audit of the Medical Care Cost Recovery Program*

Project No.: N/A

Date of Report: Undated draft report

Recommendation/ Actions	Status	Completion Date
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We recommend that you improve MCCR program activities by:

a. Requiring the Chief Network Officer to ensure that VISN Directors more actively manage network MCCR program activities to include (1) developing performance measures to improve the timeliness and accuracy of billings, and the management and collection of accounts receivable, (2) monitoring the performance results, (3) taking corrective action to improve performance gaps, and (4) enhancing communication and coordination with Regional Counsel in an effort to improve recoveries on accounts receivable referred for collection.

Concur

The Office of the Chief Financial Officer (CFO) is working closely with the Office of the Chief Network Officer (CNO) to accomplish this recommendation. We have recently completed a series of network-based training sessions with staff from network offices and their respective medical centers in attendance. The participants heard presentations from the CNO and the CFO on the importance of increasing the revenue. Staff from the Headquarters CFO Revenue Office, field staff and contractor representatives, conducted the training. The participants were tasked with the responsibility and authority to initiate procedural changes to ensure that these and other recommendations were completed. Each network team was tasked with the development of an action plan to implement changes to increase recoveries and to demonstrate accomplishment of recommendations. Additional on-site visits with representatives from the Headquarters Revenue Program (formerly MCCR) and an external consulting team will be scheduled upon request from the Network Director to assist in the assessment of medical center revenue programs. It is estimated that this process will be completed within the next six months.

VHA established VISN collection goals as the performance indicator. The MCCR Diagnostic Reports have been formatted into templates, which are accessible through The VA Intranet. Networks can access these diagnostic measures and self-monitor items

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JUNE 26, 1998 (Continued)

such as billing lag time reports, accounts receivable, and other revenue processes.
(These indicators are not routinely being monitored by Headquarters CFO staff.)

The CNO is fully supportive of these efforts and has recently written letters to all Network Directors whose collections are 90% below the goal attainment level for the first half of the fiscal year. The CNO has indicated that their progress will be closely monitored with data provided from the CFO.

Additionally the Under Secretary for Health (USH) has addressed the Network Directors, in memoranda, face to face meetings and through individual telephone contacts. The USH has emphasized the importance of this program. A monthly report is provided to the USH and CNO on the collection performance of each network. This reemphasis has resulted in VISNs working closely with Regional Counsels to improve recoveries on accounts receivable.

In process

On-going

a. Mandating the use of management tools (Preregistration, Autobiller, and Diagnostic Measures) at all facilities to better ensure veterans' health insurance carriers are identified, appropriate billing is accomplished in a timely manner, and collection of Accounts receivable is pursued effectively.

Concur

Use of these tools was stressed at the network training sessions as indicated in the Above response, as well as in numerous conference calls, previous training sessions, and Newsletters.

Software installation is mandated upon release, however, the use of the software is not mandated. The CFO's Re-engineering Committee has prepared a directive mandating the use of the preregistration software and processes at all medical centers. This directive will be undergoing concurrence through VHA Headquarters within the next several weeks. The directive will include instructions for standardizing inconsistency checks that must be placed on various fields within the pre-registration software. A report will be submitted to the CFO Revenue Office, by each medical center, for baseline analysis of incomplete registration data. The report will then be generated on a quarterly or semi-annual basis to determine the progress being made on improving our data bases and customer service. The Re-engineering Committee has been asked to develop a similar directive with respect to cleaning up the Integrated Billing (IB) Software insurance file. This directive will provide a mandate for turning on all Autobiller functions within the IB software upon completion of the clean-up effort.

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JUNE 26, 1998 (Continued)

The MCCR Diagnostic Reports have been formatted into templates, which are accessible Through the VA Intranet. Networks can access these diagnostic measures and self-monitor items such as billing lag time reports, accounts receivable, and other revenue processes. The networks have supported these Diagnostic Measures, and we have Every assurance that their support will continue.

In process 7/31/98 & on-going

c. Establishing performance standards for administrative and clinicial staff involved in all phases of MCCR activities to include patient registration, billing, collection, and utilization review and requiring VHA managers to monitor performance results and take action to improve performance gaps.

Concur

VHA has established VISN collection goals as the performance indicator. Network Directors will be directed to establish appropriate performance standards since they are responsible for the administration of the collection activities.

In process 10/1/98

d. Better promoting the importance of the MCCR program by ensuring VHA facility staff, patients, and Veteran Service Organizations have access to information demonstrating (1) how MCCR recoveries benefited each facility's ability to provide medical services to patients and (2) the detrimental effect on operations if MCCR funds were not available to supplement facility budgets.

Concur

The USH and VHA CFO held special Veterans' Service Officer meeting on May 7, 1998, to discuss the Revenue Program. Additional updates will be provided to the VSOs through regularly scheduled meetings.

The CFO Revenue Office has developed three brochures covering the issues of third Party billing and veterans copayments. These brochures are *The Ins & Outs of Veterans Copayments & Health Insurance at the VA*; *The Medication Copayment Policy*, and, *Medical Care Recovery Program: A Resource for America's Veterans*. Numerous copies of all three are distributed to every VA medical center on a quarterly basis and are available through the Revenue Office. The Revenue Office has also prepared a tabletop display for field use that highlights the new benefits, services and policies concerning VA's medical care collection activities. These materials highlight the fact that

MEMORANDUM FROM THE UNDER SECRETARY FOR HEALTH
DATED JUNE 26, 1998 (Continued)

Collections now stay in the local area. Additionally, the Revenue Office is planning presentations to Veterans Service Organizations. A set of posters calling attention to the need for insurance disclosure, and how veterans and the VA benefit from insurance disclosure, is presently being developed by the VHA CFO and the Chief Education officer for field distribution.

In process

On-going

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Director, MCCR Program (174)

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Ranking Democratic Member, Subcommittee on Health,
House Committee on Veterans' Affairs