



Department of Veterans Affairs

Office of Inspector General

Audit of the Medical Care Collection Fund Program

***VHA can significantly
increase MCCF revenues.***

Report No. 01-00046-65

February 26, 2002

VA Office of Inspector General
Washington, DC 20420

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**DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420**

Memorandum to the Acting Under Secretary for Health (10)

Audit of the Medical Care Collection Fund Program

1. The purpose of the audit was to: (i) evaluate the implementation of the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF) program; (ii) follow-up on recommendations made in a previous audit; and, (iii) determine if there were opportunities to increase MCCF program recoveries.
2. The Veterans Health Administration (VHA) could enhance MCCF revenues by requiring Veterans Integrated Service Network (VISN) and VA medical facility Directors to better manage MCCF program activities. Recommendations made in our prior review of the MCCF program - "Audit of the Medical Care Cost Recovery Program," Report No. 8R1-G01-118, dated July 10, 1998, were not adequately implemented and conditions identified during that audit, including missed billing opportunities, billing backlogs, and inadequate follow-up on accounts receivable, were continuing. We concluded that, by effectively implementing our previous recommendations, VHA could have increased collections by about \$135.2 million in Fiscal Year 2000 (24 percent). Additionally, clearing the backlog of unissued bills that currently totals over \$1 billion would result in additional collections of about \$368.4 million.
3. We recommended the following actions to improve the MCCF program:
 - Communicate MCCF performance goals/expectations to VISN Directors and medical facility Directors and hold them accountable for results by measuring performance and addressing performance gaps.
 - Improve medical record documentation so that health care treatment is coded accurately and properly billed.
 - Ensure that medical facilities use VHA's preregistration software.
 - Establish performance standards for clinical and administrative staff involved in all phases of the MCCF process (patient registration, coding, billing, collection, and

utilization review). Make additional resources available for MCCF functions as justified by the performance standards.

- Expand training for MCCF personnel (patient registration staff, physicians, coders, billing clerks, collection staff, and utilization review staff).
- Follow up with insurance carriers on delinquent accounts receivable.
- Promote the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

4. You concurred with the findings and recommendations. 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.

(original signed by:)

MICHAEL SLACHTA, JR.

Assistant Inspector General for Auditing

RESULTS AND RECOMMENDATIONS

VHA Can Significantly Increase Medical Care Collection Fund Revenues

Background

In accordance with Title 38, U.S.C. Sections 1710, 1712, 1722A, and 1729, VA collects reimbursements from third-party health insurers and certain veterans to offset the cost of medical care and medications for treatment of nonservice-connected conditions. In 1986 VA began billing health insurers for health care using a per diem charge basis. Per diem was based on calculations of VA's costs to provide medical care. Under the Medical Care Cost Recovery (MCCR) program, MCCR revenues in excess of program costs were transferred to the Department of Treasury as proprietary receipts.

The Balanced Budget Act of 1997 (Public Law 105-33) required VA to establish the Medical Care Collection Fund (MCCF), which replaced the MCCR program. This law permitted VA to retain MCCF collections to supplement appropriations and finance the cost of providing medical care to veterans.

Public Law 105-33 also authorized VA to bill "reasonable charges" for medical care provided on or after September 1, 1999. Reasonable charges are defined as amounts that insurers would pay private sector health care providers in the same geographic area for the same services. Billing reasonable charges is more labor intensive and time consuming than billing cost based per diems, but results in higher recoveries.

The effectiveness of billing reasonable charges relies upon accurate documentation of the medical care provided, use of consistent business processes, and compliance with policies and procedures. Billing and collection is the end of a process that includes:

- Determination of patient eligibility and entitlement for health care.
- Verification of the patient's insurance coverage.
- Coordination of care with the insurance carrier.
- Documentation of treatment in the patient's medical record.
- Coding of the diagnosis and/or medical procedures using industry standard codes, such as the International Classification of Disease (ICD-9) and Current Procedural Terminology (CPT-4) systems.

These processes must work together to produce timely and accurate bills.

Veterans Health Administration (VHA) officials believed that the authority to bill for reasonable charges and the ability to retain MCCF revenues would motivate managers to increase collection efforts. Minimum annual MCCF collection goals were established for Veterans Integrated Service Networks (VISNs) and member medical facilities to further encourage MCCF efforts. As shown below, between fiscal years (FYs) 1998 and 2000 collections were essentially flat. VHA did not achieve its collection goals, even after lowering the FY 2000 collection goal by approximately 10 percent below the FY 1999 goal. In FY 2000, 12 of the 22 VISNs did not meet their goals, and 10 of these 12 VISNs collected less in FY 2000 than in FY 1999.

VISN Directors told us that the flat collections in FY 2000 were due in large part to the transition to reasonable charges, which required implementation of new billing processes and training for medical center staff. Collections increased significantly to \$771 million for FY 2001, or approximately 35 percent more than the \$573 million collected in FY 2000. According to MCCF program managers, the increased rate of collection is due to the fact that MCCF staffs are now better trained in the various facets of billing and that there are now higher reimbursement rates under reasonable charges.

<u>Fiscal Year</u>	<u>Goal (Millions)</u>	<u>Collections (Millions)</u>
1997	\$544	\$520
1998	\$634	\$560
1999	\$671	\$574
2000	\$605	\$573
2001	\$605	\$771

Recommendations from the 1998 Audit Were Not Adequately Implemented

On July 10, 1998, we issued our report - "Audit of the Medical Care Cost Recovery Program." We reported that VHA could increase MCCR recoveries by over \$83 million by requiring VHA facilities to: (1) use management tools, such as preregistration software to identify and bill insurance carriers more timely; (2) more aggressively pursue collection of accounts receivable; (3) establish and monitor performance standards for MCCR staff; and, (4) publicize the benefits of the MCCR program to veterans.

VHA concurred with our findings, recommendations and estimated benefits. The VHA action plan included VISN-based training sessions and tasking for procedural changes to implement our recommendations. VISN Directors were also required to establish appropriate performance standards. VHA held meetings with Veterans' Services Officers and distributed informational brochures describing third-party billing and the circumstances under which veterans would make co-payments. Additionally, veterans were informed that MCCR collections would be returned to benefit veterans in the region where the revenues were derived. However, the recommendations were not adequately

implemented and conditions identified during that audit, including missed billing opportunities, billing backlogs, and inadequate follow-up on accounts receivable, were continuing.

As discussed below, 19 percent of facilities were not using the preregistration software and staff were not following up with insurance carriers on delinquent accounts receivable as we recommended. In addition, VHA had not established performance standards for clinical and administrative staff conducting patient registration, coding, billing, collection, and utilization review. Finally, VHA still needs to better educate veterans about the importance of MCCF collections to the medical facility and to dispel any misconceptions veterans have that reporting insurance information to VA could result in loss of insurance coverage or increased premiums.

Billing For All Nonservice-Connected Medical Care Would Increase MCCF Revenues

We reviewed a statistical sample of 250 patient discharges selected from 739,634 patients discharged from inpatient care during the period October 1, 1999 to September 30, 2000. We determined that 31 of the 250 patients (12.4 percent) had potentially billable insurance, and that 16 of the 31 cases had medical care provided that should have been billed, but was not. The value of the unbilled care totaled \$17,941¹. These cases were unbilled because:

- The attending physician's participation was not documented (11 cases totaling \$4,436).

In one case, the MCCF coordinator stated that care totaling \$1,008 was not billed because the patient's medical record did not contain adequate documentation of the attending physician's supervision of care provided by a resident. The MCCF coordinator stated that they could have billed for the care if the physician's level of involvement had been adequately documented.

- The veteran's file was missing or contained inaccurate insurance information (2 cases totaling \$8,662).

In one case, a veteran transferred from one VA facility to another. The transferring facility had current insurance information and billed the veteran's insurance provider for the institutional portion of the medical care. However, the receiving facility did not have current insurance information and did not bill for medical care totaling \$6,511.

¹ In 4 of the 16 cases, there were multiple reasons why billing opportunities were missed.

- Errors were made by MCCF staff because of poor training (3 cases totaling \$3,920).

In another case, institutional and professional fees totaling \$18,244 were billed, but multiple instances of medical care totaling \$736 were not billed. MCCF billing staff erroneously believed that procedures ordered by residents were not billable, whether or not appropriate attending physician documentation was present.

- There was insufficient MCCF staffing to process the bills (2 cases totaling \$831).

Professional fees were not billed because MCCF staff were instructed to focus only on inpatient institutional and outpatient billing due to the increased workload demands created by implementation of reasonable charges. For example, the institutional portion of medical care totaling \$9,069 was billed, but professional fees totaling \$807 were not billed.

- Incomplete medical records resulted in untimely procedure reports (2 cases totaling \$92).

Professional fees totaling \$49 were not billed because billing information was not available at the time the MCCF coding clerks forwarded the cases to the MCCF billing clerks.

We estimate that in FY 2000, about \$53.1 million was not billed for care provided to about 47,000 patients in the universe of about 740,000 discharged inpatients. Based on VHA's current collection rate (approximately 35 percent of amounts billed), we estimate that VHA could have increased collections by \$18.6 million if the medical care provided had been appropriately billed.

(See Appendix II on page 9 for a description of our sample methodology and results.)

Ensuring that Veteran Insurance Information is Accurate Could Increase MCCF Collections

Our review of a statistical sample of 250 veterans discharged during FY 2000 found that, according to VHA administrative records, 215 veterans did not have billable insurance. We contacted veterans, their spouses, and/or employers in 40 of the 215 cases to verify the accuracy of the insurance information obtained during patient registration. These 40 cases were judgmentally selected for follow up based on the veterans' ages, their employment status, and whether they had previously reported insurance. We found that information in VA's administrative records was not reliable. In 20 of the 40 cases we were unable to contact the veteran because of incorrect phone numbers. In addition, for 7

of these 40 cases the employment information was erroneous. We conducted additional tests of patient registration procedures by contacting 10 veterans who were on a medical facility's 'Patients with Unidentified Insurance List' for March 2001. We found that 3 of the 10 veterans did have health insurance coverage.

Questionnaire responses received from 135 VHA facilities indicated that 25 facilities (19 percent) are still not using the preregistration software patch. This patch to the Veterans Health Information Systems and Technical Architecture (VISTA) system forces the gathering and updating of pertinent patient demographic data by prompting MCCF staff to input this necessary information. VHA Directive 98-042, dated September 23, 1998, mandated the use of this software patch by all VHA facilities. A helpful feature of the patch is that the veterans are asked to provide their insurance information before they come to the hospital. VHA program officials stated that veterans are more willing to provide health insurance information through this process. VHA Directive 98-042 noted that during FY 1997, use of this VISTA software at 7 pilot sites produced \$5.6 million in new revenue.

Reducing Billing Time Would Increase MCCF Collections

We reviewed the number of days that elapsed from the date of care to the date of billing for 500 billings randomly sampled from approximately 3,900,000 bills issued during the period October 1, 1999 to September 30, 2000. On average, the medical centers took about 95 days to bill for care provided (84 days average for inpatient bills and 108 days average for outpatient bills). By contrast, our 1998 audit found that medical centers took on average 48 days to bill for services and, in calendar year 2000, private industry averaged only 10 days to issue bills.

The number of VA unbilled cases has increased significantly since billing for reasonable charges began. VHA's Unbilled Care Report shows the average amount billed multiplied by the number of potentially billable instances of medical care. The September 2001, report shows \$1,052,660,528 in unbilled (\$251 million for inpatient care, \$776 million for outpatient care, and \$26 million for prescriptions) medical care. The backlog of unbilled services has increased 22 percent since May 2001, when the backlog totaled \$860 million. Based on the FY 2001 collection rate (approximately 35 percent of the amount billed), eliminating this unbilled care backlog could result in additional collections of \$368.4 million.

Follow-up Telephone Contacts with Insurance Carriers Could Increase Collections

VA policy requires that accounts receivable staff follow up on delinquent MCCF accounts. A second notice should be sent to the insurance carrier 45 days after issuance of the initial bill and, if no response is received, a third notice should be sent 30 days later. At the time the third notice is sent, telephone follow-up is required with the insurance carrier. If there is no response from the insurance carrier within 30 days after the third notice, the case is to be referred to the VA Regional Counsel for collection action.

To determine the effectiveness of MCCF debt collection procedures, we reviewed the collection actions on a statistical sample of 250 inpatient bills issued during FY 2000. We selected this sample from a universe of approximately 234,500 bills valued at about \$1.4 billion, issued during FY 2000. Results showed that insurance recoveries were 12.5 percent higher when telephone contact was made with insurance carriers. For example:

- An insurance carrier was billed on July 13, 2000, for medical care totaling \$28,862. MCCF collections staff contacted the carrier on August 21, 2000, and were told that the bill was being reviewed. During a telephone contact made on August 28, 2000, the insurance carrier's representative indicated that \$20,000 would be authorized. However, as a result of additional negotiation during the call, VA collected \$23,800 on September 15, 2000.

We found that 193 of the 250 sampled accounts receivable (77 percent) were not followed up by telephone. We estimate that VHA could increase collections by about \$116.6 million annually if the required telephone follow-up calls are made to the insurance carriers.

(See Appendix II on pages 10 and 11 for a description of our sample methodology and results.)

Conclusion

VHA could increase MCCF collections by over \$503.6 million.

Recommendations

We recommend that the Acting Under Secretary for Health improve MCCF program operations by:

1. Providing MCCF performance goals/expectations to VISN Directors and medical facility Directors and holding them accountable for results by measuring performance and addressing performance gaps.

2. Improving medical record documentation so that treatments are coded accurately and properly billed.
3. Ensuring that VA medical facilities use the preregistration software as required.
4. Establishing performance standards for clinical and administrative staff involved in all phases of the MCCF (patient registration, coding, billing, collection, and utilization review). Making additional resources available for MCCF functions as justified by performance standards.
5. Expanding training for MCCF personnel – patient registration staff, physicians, coders, billing clerks, collection staff, and utilization review staff.
6. Following up with insurance carriers on delinquent accounts receivable.
7. Promoting the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

Comments of the Acting Under Secretary for Health

The Acting Under Secretary for Health concurred with the findings and recommendations and provided an implementation plan which addressed each recommendation and included corrective actions taken and planned. *(See Appendix III on pages 12-18 for the full text of the Acting Under Secretary's Comments.)*

Office of Inspector General Comments

The Acting Under Secretary's comments and implementation plan meet the intent of the recommendations and we consider all issues resolved. However, we will follow up on implementation of planned corrective actions.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The purpose of the audit was to: (i) evaluate VA's implementation of the MCCF program; (ii) follow-up on recommendations made in a previous audit; and, (iii) determine whether there are opportunities to increase MCCF program recoveries.

Scope and Methodology

Our current audit focused on FYs 2000 and 2001 activities and included analyses of MCCF billings and collections. We assessed MCCF policies, procedures, and operations. To accomplish our objectives we reviewed:

- A statistical sample of patients discharged during the period October 1, 1999 to September 30, 2000 (universe was about 740,000 discharges), to determine whether health insurers were billed accurately and timely.
- A statistical sample of inpatient bills issued to health insurers during the period October 1, 1999 to September 30, 2000 (universe was about 234,500 bills totaling \$1,365,451,895), to evaluate the effectiveness of collection efforts.
- Questionnaire responses from 22 VISN Directors to determine their role and responsibility for MCCF and actions taken to implement recommendations made in the 1998 audit report.
- Questionnaire responses from 135 VHA medical facilities to evaluate local MCCF billing and collection procedures and controls.
- VHA's monthly Unbilled Care Reports for the months of May through September 2001.

SAMPLE METHODOLOGY AND RESULTS

Our audit of the MCCF program involved sampling plans for billing inpatient care and managing accounts receivable.

A. Billing Inpatient Care

Audit Universe

The audit universe consisted of about 740,000 inpatient discharges from all VHA facilities during the period October 1, 1999 to September 30, 2000.

Sample Design

The purpose of our review 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 250 cases from the approximately 740,000 inpatient discharge universe.

Sample Results

Projected Cases of Unbilled Care

Our sample of 250 episodes of inpatient care showed that for 16 episodes, additional care should have been billed at a cost of \$17,941. Based on our sample results, we project that the universe of about 740,000 patient discharges contained 47,337 cases with unbilled care. This projection has a confidence level of 95 percent and a confidence interval +/- 3.034, resulting in a lower limit of 24,899 and an upper limit of 69,774 cases. Based on the average unbilled amount of \$1,121.31 per case (\$17,941/16), we estimate that the 47,337 cases totaled \$53,079,451 in unbilled care. Based on VHA's current collection rate (approximately 35 percent of the amount billed), we estimate that VHA could have increased collections by \$18,577,808.

Population Size	Sample Size	Number/ % of Billable Cases	Projected Number of Cases	Amount Billable Care	National Collection Rate	Projected Collections
739,634	250	16 (6.4%)	47,337	\$53,079,451	35%	\$18,577,808

B. Managing Accounts Receivable

Audit Universe

The audit universe consisted of about 234,500 third-party inpatient bills totaling \$1.4 billion issued in FY 2000. This information was extracted from VA's Allocation Resource Center billed medical care reports.

Sample Design

The purpose of our review was to evaluate collection activity of third-party inpatient bills. The sample consisted of 250 of the approximately 234,500 third-party bills in the universe and was based on an attribute sampling design at the 95 percent confidence level.

Sample Results

Comparison of Collection Results With and Without Telephone Contact

Results showed that telephone follow-up was not made in 193 of 250 episodes of inpatient care billed. In 57 of the 250 bills sampled, VHA staff pursued collections by telephone contact with insurance carriers. The collection rate on these bills was 28.1 percent of the amount billed (\$182,863/\$651,627). In 193 of the sampled bills, VHA staff did not pursue collections by telephone contact with insurance carriers, and the collection rate was 15.6 percent (\$155,464/\$997,105). Accordingly, we estimate that an additional \$124,348 could have been collected on these 193 cases if telephone follow-up had been made.

Item No.	Description	With Telephone Contact	Without Telephone Contact
1	Sample Count	57	193
2	Collections – Sample	\$182,863	\$155,464
3	Billed Amount – Sample	\$651,627	\$997,105
4	Collection Rate – Sample	28.1%	15.6%
5	Potential Collections with Telephone Contacts (\$997,105 x 28.1%)		\$279,812
6	Additional Benefit (\$279,812 - \$155,464)		\$124,348

APPENDIX II

Based on these sample results, we projected that the universe of 234,464 inpatient bills contained 181,006 bills with no telephone follow-up. This projection has a confidence level of 95 percent and a confidence interval +/- 5.198, resulting in a lower limit of 168,818 and an upper limit of 193,194. Based on the average additional collected amount of \$644.29 per bill (\$124,348/193), we estimate that collections for the 181,006 bills could have been increased by \$116,620,356.

Population Size	Sample Size	Number / % Bills Without Telephone Follow-up	Projected Number of Bills Without Telephone Follow-up	Additional Collections per Bill if Telephone Follow-up Made	Additional Collections
234,464	250	193 (77.2%)	181,006	\$644.29	\$116,620,356

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

Department of
Veterans Affairs

Memorandum

Date: February 13, 2002

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

Subj: OIG Draft Report: ***Audit of the Medical Care Collection Fund (MCCF) Program*** (Project No. 2001-00046-R5-0011/EDMS #163165)

To: Assistant Inspector General for Auditing (52)

1. Thank you for the opportunity to respond to the referenced draft report. VHA concurs in your findings and recommendations, and your conclusions reflect priority improvement opportunities that we have also targeted. A detailed plan of corrective actions is attached.

2. As you are aware, Secretary Principi has identified the MCCF program as a key departmental program area, and he directed the Under Secretary for Health to develop a revenue cycle improvement plan based on prescribed, detailed recommendations to improve collections. The plan, which was finalized and distributed in September 2001, is based on the principles of systemwide standardization and accountability. In the plan, we identify major challenges, along with proposed corrective actions, responsible program offices and implementation timeframes. A copy of the improvement plan is also included in this response.

3. As referenced in our action plan, all of the issues identified in your report are also addressed in the improvement plan, and we believe that we are making significant progress in implementing a systematic approach to improved collections processing. Our statistical monitors are already reflecting growth trends.

4. Four diagnostic measures reports are currently provided for review by VHA's National Leadership Board, with comparative VISN profiles for a broad range of collection activities. The reports are also made available to VISN and medical center directors for easy assessment of individual facility standing. Every effort is also being made to improve coding accuracy. Policy revisions are being developed to reflect enhancements to the MCCF initiative, and a CFO-directed work group is in the process of developing standardized templates and encounter forms to assist providers in their medical record documentation. Renewed efforts are also being made to assure full compliance in use of required preregistration software.

5. In addition, VHA's Compliance and Business Integrity Office continues to make progress in establishing monitoring protocols for staff involved in MCCF activities. Comprehensive indicators have been approved by the National Compliance Advisory

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

Page 2 OIG Draft Report: ***MCCF Program***

Board and the Performance Measures Work Group, and a standardized national compliance audit plan that incorporates all of the measures is also nearing the final stage of development. Compliance monitoring is an ongoing process, and modifications will be incorporated as necessary.

6. Training of MCCF personnel is another important issue that is addressed in the improvement plan. Also included is education of veteran patients and staff about changes in copayment requirements and the benefits to the health care system that the MCCF provides.

7. The plan also addresses improvements in follow up actions with insurance carriers. Several years ago, the Revenue Office entered into a contract with a private vendor to pursue outstanding insurance reimbursements for cases referred by individual medical centers. This action has proven to be very successful and we continue to pursue similar options after the current contract expires.

8. In summary, we believe that the VHA Revenue Cycle Improvement Plan effectively summarizes our vision to improve collections. With the full commitment of our top management officials, implementation of our plan appears to moving in the right direction, and notable improvements have already been realized. We appreciate OIG's ongoing efforts in helping us to prioritize needed actions and look forward to sharing anticipated future successes. If additional information is required, please contact Margaret M. Seleski, Director, Management Review and Administration Service (105E), Office of Policy and Planning (105), at 273-8360.

(Original signed by:)

Frances M. Murphy, M.D., M.P.H.

Attachments

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

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

Name of Report: Office of the Inspector General (OIG) Draft Report: ***Audit of the Medical Care Collection Fund (MCCF) Program***

Report Number: 2001-00046-R5-0011

Date of Report: undated draft

Recommendations/ Actions	Status	Completion Date
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We recommend that the Under Secretary for Health improve MCCF program operations by:

- 1. Providing MCCF performance goals/expectations to VISN Directors and medical facility Directors and holding them accountable for results by measuring performance and addressing performance gaps.**

Concur

In September 2001, VHA published a revenue cycle improvement plan, which has been provided to the OIG as an attachment to this response. The plan was developed under direction from Secretary Principi to serve as a comprehensive, fundamental guide in defining VHA's vision in recognizing the key role that third party collections play in overall system operations. All of the recommendations made in this report are addressed in the improvement plan, and actions are either underway or planned to implement improvement strategies.

Actions in response to this recommendation are included in Section IX (page 46) of the plan, which defines roles, responsibilities and accountability at all levels of the revenue collection process. To assist performance assessment, four different diagnostic measures reports are currently compiled on a monthly basis and reviewed by VHA's National Leadership Board. The reports provide comparative VISN profiles of completed registration percentages, insurance verification status updates, OPT billing lag times and inpatient billing lag times. Other monthly statistical reports are also prepared for the National Leadership Board that focus on specific billing and collection activities. The reports are also made available to VISN and individual medical center directors to assess how each facility compares in program specific collection activity with all other facilities and to identify outlier facilities that might require additional administrative intervention.

In Process

Ongoing

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

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2. Improving medical record documentation so that treatment is coded accurately and properly billed.

Concur

Section V, Item 8 (pp. 22-23) of the Revenue Cycle Improvement plan requires that VHA enforce the national documentation policy contained within M-1, Part 1, Chapter 5, which addresses all issues related to medical records and documentation. A work group is currently revising this policy to reflect enhancements to the MCCF initiative, and the new revisions are expected to be published by August 2002. Another CFO-directed work group is collaborating with program staff in Patient Care Services to develop standardized templates and encounter forms to assist health care providers in improving documentation practices. Standardized templates and encounter forms for mental health and primary care services are currently being field tested, with anticipated implementation by Spring 2002. Templates and encounter forms for other health services are also being developed.

In Process August 2002 and Ongoing

3. Ensuring that VA medical facilities use the preregistration software as required.

Concur

Strengthened efforts are being made to assure that field facilities are in compliance with this requirement, which is emphasized in the improvement plan (Section V, Item 1, p. 18). VHA's Revenue Office will include discussion of the pre-registration directive during an upcoming national conference call, and will also prepare an article for the Revenue Office *FastTrack* publication on the benefits of using the software. Field compliance will be closely monitored, and follow up corrective actions will be taken as necessary with non-compliant sites.

Planned March 2002 and Ongoing

4. Establishing performance standards for clinical and administrative staff involved in all phases of the MCCF (patient registration, coding, billing, collection, and utilization review) and requiring VISN and VA medical facility Directors to monitor performance results and take action to improve

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

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performance gaps (such as, making additional resources available for MCCF functions as justified by performance standards).

Concur

In response to requirements included in the improvement plan, VHA's Compliance and Business Integrity Office (CBI) continues to make significant progress in developing and implementing business auditing/monitoring protocols for clinical and administrative staff involved in MCCF activities. Indicators have been approved by the National Compliance Advisory Board as well as the Performance Measures Work Group. The indicators were also presented to the National Leadership Board at their January meeting by VHA's Chief Financial Officer. Included among the CBI indicators are monitoring guides for diagnostic and procedural coding accuracy, billing accuracy, claims denials and patient registration completeness. When VA is a payer for non-VA care, monitors will also be established to verify the absence of provider referral conflicts and the accuracy of bills received for payment. A standardized national compliance audit plan that incorporates these measures is also nearing the final stage of development, and will be ready for a VHA-wide pilot testing by the end of February 2002. Refinements to the plan will be finalized in April 2002 at the National CBI Conference to be held in Chicago.

CBI monitoring will be an ongoing process, and system improvements will be initiated continually on an as-needed basis. New diagnostic measure reports will be developed and provided to all facilities to help them assess their revenue collection effectiveness. As already reported, four different statistical reports are currently prepared from the diagnostic measures reports and are provided on a monthly basis to the National Leadership Board. Other statistical reports are provided to display billing and collection activities at the VISN level. These reports provide VISN and medical center directors with data to evaluate their performance in program specific areas.

In Progress May 2002 and Ongoing

- 5. Expanding training for MCCF personnel – patient registration staff, physicians, coders, billing clerks, collection staff, and utilization review staff.**

Concur

COMMENTS OF THE ACTING UNDER SECRETARY FOR HEALTH

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Section V Item 4 (p. 20) and Section 10 (pp.24-25) of the improvement plan specifically address the need to assure that VHA employees are knowledgeable and have an underlying rationale behind requirements that will facilitate and enhance not only the data capture process, but also the patients' and employees' communication and interaction.

The Revenue Office and Health Information Management Office (HIM) continue to identify ongoing training opportunities for MCCF personnel. In September 2001, the two offices sponsored a training session for HIM and billing personnel. Forty-four field staff selected from the VISNs participated in the 3.5 day session, entitled "Coding Boot Camp." The training focused on documentation, coding and billing principles. Those participants will now train other appropriate staff within their VISNs. In addition, HIM staff members conduct ongoing monthly satellite conferences on documentation and coding. Topic specific agendas are regularly announced throughout the system and facility staff are encouraged to attend. Employee feedback about the effectiveness of the training is sought, and program enhancements are made as needed.

Completed and Ongoing

6. Following up with insurance carriers on delinquent receivables.

Concur

The improvement plan also addresses the need for supplemental follow-up activities (Section V Item 20, p. 32; Item 24, p. 35) on delinquent receivables. As the plan describes, VHA is taking a variety of approaches in our effort to implement and nationally mandate a consolidated approach for follow up on outstanding third party receivables. For example, more than three years ago, the Revenue Office entered into a claims collections follow up contract with a private vendor that has proven to be very successful in generating outstanding insurance reimbursements. Each medical center identifies specific outstanding accounts for vendor follow up. This contract will expire in the near future, and the Revenue Office is exploring the capabilities of other vendors for comparative options. A key in this selection is vendor software compatibility with VA's software systems.

Completed and Ongoing

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7. Promoting the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

Concur

Section V Item 3 (p. 19) of the improvement plan addresses the need to develop and implement an education program designed for veterans to inform them of the benefits of collections dispel any myths about perceived negative impacts on their care. Two new informational pamphlets about copayment changes have recently (December 2001 and January 2002) been provided to all facilities for patient distribution. One of the pamphlets addresses changes in the outpatient copayment. The second focuses on medication copayments. Posters were concurrently produced and distributed with the pamphlets. We are in the process of finalizing another pamphlet that explains why VA requires health insurance information from its patients. In addition, informational websites have been updated with the changes in copayment requirements. Two flyers have also been designed to explain the copayment changes, and they are being inserted into the monthly patient copayment bills over a four-month period (beginning in December 2001).

Completed and Ongoing

MONETARY BENEFITS
IN ACCORDANCE WITH IG ACT AMENDMENTS

Report Title: Audit of the Medical Care Collection Fund Program

Report Number: 01-00046-65

<u>Recommendation</u>	<u>Explanation of Benefits</u>	<u>Better Use of Funds</u>
1, 2, 3, 4, 5, 7	Ensuring that all billable nonservice-connected medical care is billed would increase collections.	\$ 18,577,808
1, 2, 4, 5	Eliminating the backlog of unbilled medical care would increase collections.	368,431,185
4, 5, 6	Aggressively pursuing collection of delinquent accounts receivable through telephone contacts with insurance carriers would increase collections.	<u>116,620,356</u>
	TOTAL	<u>\$503,629,349</u>

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