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IDENTIFYING THE CAUSES OF INAPPROPRIATE BILLING PRACTICES BY THE U.S. DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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IDENTIFYING THE CAUSES OF INAPPROPRIATE BILLING PRACTICES BY THE U.S. DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, OCTOBER 15, 2009

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:09 a.m., in Room 334, Cannon House Office Building, Hon. Glenn C. Nye presiding.

Present: Representatives Michaud, Snyder, Nye, Perriello, and Brown of South Carolina.

OPENING STATEMENT OF HON. GLENN C. NYE

Mr. NYE [presiding]. Good morning. I would like to bring the Subcommittee on Health hearing to order and apologize for the late start. Chairman Michaud will be with us a little bit later and asked me to Chair for him in the meantime so thank you all for being here. Before we get started, I would like to ask for unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks. Hearing no objections, so ordered.

Again, I would like to thank everyone for attending this important hearing. Today's hearing will focus on the inappropriate billing practices of the U.S. Department of Veterans Affairs (VA), where veterans receive a bill for the wrong amount or get a bill that they should not have received in the first place. Unfortunately, inappropriate billing affects both service-connected veterans and non-service-connected veterans. For example, a veteran with a service-related spinal cord injury may be billed for the treatment of a urinary tract infection. Now, the urinary tract infection may clearly be linked to, and a result of, the service-connected injury. However, veterans are still receiving bills for the treatment of such secondary conditions. As a result, these veterans may be forced to seek a time consuming and burdensome readjudication of their claim indicating the original service-connected ratings.

It is my understanding that one of the reasons for inappropriate billing of secondary conditions is that the VA cannot store more than six service-connected conditions in their information technology (IT) system. It is also my understanding that the VA is taking steps to correct the deficiency but the problem has not been fully resolved and our veterans continue to receive inaccurate bills.

Non-service-connected veterans also encounter overbilling and inappropriate charges for copayments. One issue that I have been made aware of repeatedly is that some non-service-connected veterans receive multiple bills for a single medical treatment or health care visit.

It is evident that inefficiencies in the billing system exist where something is inappropriately triggering the multiple billing episodes. It may be simple human error, or IT error, but this has the potential of imposing an unnecessary burden on our veterans. Just imagine all the time that our veterans spend and the stress that they experience in trying to resolve improper bills.

One thing is clear: inappropriate billing is not acceptable and we must do better by our veterans. Today I hope to get to the bottom of this issue. We will examine why veterans and their insurers are receiving inaccurate bills, learn what the VA is doing to address this problem, and explore how we can fully remedy the problem. We have brought together witnesses who can shed light on the problem and I look forward to their testimonies.

I would now like to yield to and recognize Ranking Member Brown for any opening comments he may have.

[The prepared statement of Chairman Michaud appears on p. 26.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. Thanks to the witnesses for coming. I am looking forward to the dialogue today.

It is the solemn mission of the Department of Veterans Affairs and the Federal Government to care for the men and women in uniform who sustain injuries and illnesses as a result of their service to our Nation. Therefore, I find it deeply troubling to hear about veterans being inappropriately billed for copayments for medical care and the medications to treat service-connected conditions.

A similar issue arose earlier this year when the Obama Administration was considering a plan to bill veterans' private insurance for service-connected care. Fortunately, this ill-conceived proposal never saw the light of day, given the fierce opposition of Members from both sides of the aisle and the veterans service organizations (VSOs). As I said then, this flies in the face of our moral obligation as a grateful Nation to care for those wounded heroes.

Thanks, and I yield back.

[The prepared statement of Congressman Brown appears on p. 26.]

Mr. NYE. Thank you, Mr. Brown. Do any other Members wish to make an opening statement? Great. I would like to go ahead and introduce the first panel. The first panel includes Mr. Fred Cowell, the Senior Health Policy Analyst from Paralyzed Veterans of America (PVA); Mr. Adrian Atizado, Assistant National Legislative Director from Disabled American Veterans (DAV); and Denise Williams, Assistant Director for Health Policy, Veterans Affairs and Rehabilitation Commission at the American Legion. Mr. Cowell, I would like to recognize you for your opening statement. Thank you for being here.

STATEMENTS OF FRED COWELL, SENIOR HEALTH POLICY ANALYST, PARALYZED VETERANS OF AMERICA; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND DENISE A. WILLIAMS, ASSISTANT DIRECTOR FOR HEALTH POLICY, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF FRED COWELL

Mr. COWELL. Chairman Michaud, Ranking Member Brown, Congressman Nye, Members of the Subcommittee, the Paralyzed Veterans of America appreciates this opportunity to present current information and its ongoing concerns regarding VA's inappropriate billing practices for medical care services delivered to America's veterans.

Mr. Chairman, as you know *The Independent Budget* has identified problems with the billing process in its 2009 and 2010 editions. Inappropriate billing for medical services is a VA systemwide problem and affects both service-connected and non-service-connected veterans. Inappropriate charges for VA medical services places unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places a burden for correction directly on the veteran, their families, or their caregivers. Additionally, PVA believes that many veterans are not aware of these billing mistakes and simply submit full payment to VA when a billing statement arrives at their home. Veterans who are astute enough to scrutinize their VA billing statements to identify erroneous charges have just begun a cumbersome process to actually correct the problem and receive a credit for the error on a subsequent VA billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible.

If the veteran contacts the VA Health Resource Center in Topeka, Kansas, concerning questions about their account, they must work through a telephone maze before reaching a representative to discuss the billing issue. The Health Resource Center representative cannot remove charges that are in dispute and can only email the reported error to the proper VA facility for consideration. The local facility then has 30 days to respond to the veteran if the veteran requests such contact. In the meantime, subsequent billing statements continue to arrive at the veteran's home and penalty charges continue to accrue. Because of extensive delays, many PVA members have foregone assistance from the Resource Center and seek assistance from their local providers who may or may not intervene on their behalf.

Mr. Chairman, the process to correct inappropriate billing is not an easy path for veterans as VA billing statements are often received months after an actual medical care encounter, and subsequent credit corrections only appear months after corrective intervention has taken place. It is often difficult for veterans to remember health care treatment dates and match billing statements that arrive months after treatment to search for billing errors. PVA's experience, as mentioned earlier, has shown that both service-connected and non-service-connected veterans are being erroneously

billed for their VA care. PVA members who are 100-percent service-connected for their spinal cord injuries report that they receive VA bills related to their service-connected condition. VA is billing these veterans for secondary medical conditions directly related to their service-connected condition. Some VA billing offices explain that because a veteran is not rated for these secondary conditions that they can freely bill for this care. This issue is amplified in our written statement to the record.

These veterans also report that their private insurance providers are often billed for VA care they receive for their service-connected conditions. PVA non-service-connected veterans report that they consistently receive multiple copayment charges for a single VA medical care service. Again, the veteran has identified a billing error the corrective process just begins. If the error is discovered by the veteran finding proper assistance is difficult and corrective action takes months to achieve. Corrective action and follow through is the veteran's responsibility because the veteran receives no acknowledgment letter from the VA that an error has actually happened. The veteran is forced to review subsequent billing statements to see if he or she actually receives a credit entry for the previous error.

Mr. Chairman, I personally have been experiencing billing errors for years concerning the services I receive from the Washington, DC, Medical Center. The quality of care I have received is of the highest caliber. But almost every billing statement I receive has several charges that are incorrect. For several years I simply paid these charges because I did not realize they were erroneous. For at least the past 3 years, I now work with my visiting nurse to review my bills for incorrect charges. She then contacts the social worker on my team and they work with the DC business office to remove incorrect charges. This is a monthly process because somehow the problem cannot be fixed on the local level and these errors continue to happen. This means that important frontline health care workers are spending their valuable time on correcting billing issues rather than caring for veterans.

Because VA has been experiencing reports from veterans across America that inappropriate billing is happening, we conducted a survey of our membership to understand the scope of the problem. In September of 2009, PVA sent an email survey to approximately 4,000 of our members regarding the issue. Within 2 weeks, we had received 449 responses to the survey. Of the 449 respondents, approximately 9 percent report receiving more than one bill for the same treatment episode; approximately 17 percent claim to have been billed directly for a service-connected condition; and another 22 percent claim that their insurance company is being billed for treatment of a service-connected condition.

Mr. Chairman, we are asking the Subcommittee to take action on the issue of inappropriate billing and to intervene on behalf of PVA members and on behalf of all veterans who are experiencing incorrect VA billing problems. PVA knows this is a national problem, as evidenced by our survey.

The stress of living with a catastrophic disability is burden enough, Mr. Chairman, without experiencing continued billing problems associated with the care we receive from the VA. Mr.

Chairman, this concludes my remarks and I will be happy to attempt to answer any questions you may have.

[The prepared statement of Mr. Cowell appears on p. 27.]

Mr. NYE. Thank you very much for your opening statement, Mr. Cowell. I would like to recognize you, Mr. Atizado, for your opening statement.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Mr. Chairman, Ranking Member Brown, Members of the Subcommittee. I would like to thank you first and foremost for inviting the DAV to present our views on inappropriate billing practices by the VA. Like my colleague here, there are numerous concerns about inappropriate billing. But we do bring two points of concern: the effects of inappropriate billing on VA's financial resources, as well as the veteran/patient, both of which affect patient care and patient satisfaction.

The efficient and the timely collection of reimbursable costs is a tremendous driver at local facilities that adds to their resources toward meeting the growing health care demands of sick and disabled veterans. However, when we compare fiscal year 2009 and the 2010 budget estimates to those of prior years, we see a dramatic increase in estimated collections for third party as well as first party and other copayments. This is concerning in light of the overall actual expected collections that have been below budget estimates, that is with the exception of fiscal year 2008 when VA actually exceed estimated collections.

If you compare, however, the fiscal year 2008 and 2010 budget estimates for medical care fund subaccounts, there is an expected increase of 50 percent for third-party collections or collections to insurance companies of veterans, and a 30-percent increase in first party and other copayments, collections from veteran/patients themselves.

The DAV is concerned that ever-increasing budget estimates and the need of local VA facilities to meet them to ensure they have adequate resources may encourage or contribute to inappropriate billing. And although it is mitigated to some extent by designating these collections as no-year funds, the exceedingly dramatic shift in gains and losses in these subaccounts can have a detrimental effect. Without facility by facility performance and trend data on collections, we are concerned that VA's ability to effectively manage the Medical Care Collections Fund (MCCF) program to enhance revenue and avoid inappropriate billing is severely impaired.

Despite efforts prompted by reports from the U.S. Government Accountability Office (GAO) and VA's Office of Inspector General (OIG) to enhance revenue collections and protect against erroneous billing, the DAV continues to receive reports from our members that inappropriate billing continues. To supplement the anecdotal evidence we have collected over the years, DAV recently conducted a survey, much like PVA, of our DAV Commander's Action Network. We asked survey recipients to participate if they believe VA has inappropriately billed them or their insurance companies. There is also the survey of 402 respondents from across the Nation, show about 43 percent receive bills for their care from VA and ap-

proximately 62 percent had other insurance coverage being billed for VA care.

And we also asked if they had received more than one bill for the same treatment, and about 18 percent affirmed. We then asked if they are billed for treatment at the VA for a service-connected condition, 42 percent, or 167 veterans, said they are. And about 55 percent confirmed that their insurance company is being billed for a service-connected related treatment.

We understand that under the law, VA must bill veterans and their insurers for providing treatment for non-service-connected conditions. However, inappropriate billing causes undue financial and emotional stress on veterans and their families. The four vignettes included in my written testimony from veterans who are being inappropriately billed goes to the heart of being a veteran-centric health care system. What is most troubling is the perception these veterans carry about VA being indiscriminating in their billing and collections, and VA being unresponsive when veterans bring their concerns to the local facility for corrective action.

Now, VA is not supposed to be a for-profit health care provider, but it is perceived as such by our veterans. And this is because in the private sector it is up to the patient to catch mistakes when they or their insurance are being inappropriately billed. We believe VA should be held to a higher standard than the private sector provider.

Mr. Chairman, as I remain in the audience for the remainder of this hearing I will listen with the ear of these four veterans and others like them about what VA is proactively doing to address their actions and ensure no future inappropriate billing occurs.

Again, we appreciate the Subcommittee's interest in this issue and we thank you for the opportunity to present our views. We will appreciate your consideration of our testimony in pressing this important matter for America's sick and disabled veterans. I will be pleased to answer any questions that you or other Subcommittee Members may have. Thank you.

[The prepared statement of Mr. Atizado appears on p. 29.]

Mr. NYE. Thank you very much, Mr. Atizado. I would now like to recognize Ms. Williams for an opening statement.

STATEMENT OF DENISE A. WILLIAMS

Ms. WILLIAMS. Mr. Chairman and Members of the Subcommittee. The American Legion appreciates the opportunity to offer our views on this very important issue. The American Legion has a long history of advocating on behalf of veterans. A very notable instance where this is evident was in March 2009 when Past National Commander David Rehbein met with President Obama and learned that the Administration planned to move forward on a proposal to charge veterans' private insurance for the treatment of service-connected injuries and illnesses at VA medical facilities. Under the proposed change, VA would bill the veteran's private insurance company for treatment of their service-connected disability. After fierce opposition from the American Legion and other veterans service organizations, the Administration dropped their plan to bill private insurance companies for treatment of service-connected medical conditions.

In June 2004, the GAO released a report which stated that VA had inadequate patient intake procedures, insufficient documentation by physicians, a shortage of qualified billing coders, and insufficient automation, all of which diminished MCCF collections. GAO conducted a followup audit in 2008 and echoed similar findings, that VA has ineffective controls over their medical center billings and collections which limits revenue from third-party insurance companies. The report also concluded that VA lacks policies, procedures, and reporting mechanisms for oversight of third-party billings and collections.

The Department of VA Inspector General's Office conducted an evaluation of the MCCF first party billings and collections practices in 2004. The report found that the veterans were inappropriately billed because of inaccurate medical facility veterans health information systems and technology architecture. In 2007, the VA OIG carried out another evaluation of 10 facilities and ascertained that there were missed billing opportunities at 10 facilities due to insufficient documentation of resident supervision. Additionally, there were cases where episodes of care were not billed due to coding staff's lack of experience and insurance companies denying payment because of billing staff placing incorrect information in the system.

In light of these findings, we recommend that VA implement continuing education of all coders and their supervisors. The American Legion urges VA OIG and GAO to conduct followup evaluations of their latest reports to determined whether VA has complied with these recommendations.

Mr. Chairman, although VA has made great strides in rectifying these issues surrounding their billing and collection practices, it is apparent that there is still room for improvement. As recent as April 2009, the American Legion compiled a total of 10 documented cases where VA erroneously billed service-connected veterans' private insurance for their service-connected medical care. In one case, an 80-percent service-connected veteran reported that his wife's private insurance had been billed repeatedly for his treatment of service-connected illness. The veteran inquired about it through the VA primary care team and was told that they will continue to be billed as long as they have private insurance. The veteran explained that he was being billed for service-connected disabilities. However, the inappropriate billing continues.

The American Legion is deeply concerned about this critical situation and contends that VA work jointly with us to investigate these and other cases, as well as collect pertinent records from affected veterans and take the necessary corrective measures. Additionally, we recommend that the VA create a means to alert coders of service-connected conditions in their system and increase efforts and focus on monitoring accounts receivable.

Finally, we would like to take this opportunity to express our thanks to Chairman Filner for the introduction of H.R. 3365, the "Medicare VA Reimbursement Act of 2009." The American Legion strongly supports this bill and would like to encourage your colleagues to follow suit.

On behalf of the American Legion, I appreciate the invitation to present our views on this very important topic. This concludes my testimony.

[The prepared statement of Ms. Williams appears on p. 34.]

Mr. NYE. Thank you very much, Ms. Williams. I would like to take the opportunity to ask a couple of question of our panel members. First of all, I would just like to say I appreciate Mr. Brown, the Ranking Member's opening comments, when he mentioned something that a number of our panelists also mentioned, about the notion that the Administration was kicking around earlier in the year about potentially charging veterans' private insurance for service-connected injuries. I want to say I was also proud to be part of that bipartisan effort along with our VSOs to raise the issue quickly to the White House. Fortunately, we were able to resolve that and get that taken off the table early.

It is clear to me that despite some of our victories, we have still got some problems in execution at the VA. I would like to ask if all of the panelists might tell me what they are hearing from their membership in terms of the amount of time that it typically takes for these inappropriate billing episodes to be resolved? If I could start with Mr. Cowell.

Mr. COWELL. In my personal experience, I generally receive a VA billing statement 3 or 4 months from the actual date of treatment. At that point, I have to go through the bill, match it. I have learned over time to match it to a home calendar that I keep so that I can track actual visit dates from my home care nurse. If I notice more than one billing in that particular month, and generally I get a single visit in a month from my home care nurse. Sometimes I am billed as often as three or four times in that month for that single service. I then have to wait for the following visit, which is the following month, to talk with her about the issue. She checks her calendar, verifies that there is erroneous billing going on. And then she goes back to the DC hospital and contacts the social worker on that team, who then reviews the chart. And they go up to the business office.

So sometimes it can take 6 to 8 months to get a correction for a billing error. And most months there is more than one billing error on my statement. And we are hearing the same thing from veterans across the country, PVA members, that it takes 6 to 8 months, if they even know that there is a billing error, to get it corrected.

Mr. NYE. Did you say that most months there is a billing error on your statement?

Mr. COWELL. That is correct.

Mr. NYE. All right, thank you. Mr. Atizado.

Mr. ATIZADO. Well, thank you for that question. The veterans that I ended up calling from our survey who said that it was okay for us to contact them, the time runs the gamut from having it corrected within a few weeks, to not being corrected at all, to being corrected for one bill and having a recurring bill; I should say recurring inappropriate bill, happen the following treatment episode or the following month. So I can certainly tell you that there is no consistency in the corrective actions. There just is not.

Some veterans have given up. Some veterans will pay. And some veterans will hold themselves in debt, and end up having an offset put on either their compensation or pension, despite the fact that it is an inappropriate bill.

Mr. NYE. Okay, thank you.

Ms. Williams.

Ms. WILLIAMS. Mr. Chairman, I believe it varies based on the case. But those 10 cases that we compiled in April, one of our Assistant Directors did follow up with the veterans and I believe there were some cases that were not resolved, and this was last week. I must say that our Executive Director did meet with our VA liaison last week and I believe that they are working on resolving those cases. So it does vary. We do not have an exact time for when they are resolved, but there are still some cases out there that have not been rectified.

Mr. NYE. Okay. Mr. Cowell, just a followup for you. You suggested that your home care nurse had been helping you go back and follow up on the inaccuracies, and I just wanted to make sure that I understood that correctly. Is that typical of your membership, to have that kind of assistance when going back and checking your bill?

Mr. COWELL. I cannot speak for our membership on this issue. But I am rather trying to bring the firsthand account of my experience. And I am astute enough, and have been coached enough, to know how to look for these errors now that I realize they are happening. I think many of our members do not even know that there is inappropriate billing going on. They receive, our non-service-connected members that would receive a copayment bill, just simply pay the bill. If they neglect to pay the bill then they receive a series of uncomfortable letters about possible penalties and other actions that can result if they do not submit payment.

If you submit payment for an inappropriate bill, there is never any followup from the VA, who then double checks to see if their billing statements are even correct. So the veteran can be out of pocket if he chooses to go ahead and pay the bill. If you delay payment then you incur penalties and charges on your account that are added on until the situation is corrected.

Mr. NYE. Okay. Thank you. I also wanted to follow up on your surveys, between you and Mr. Atizado. Did both of your organizations use the same survey? Or did you use separate surveys?

Mr. COWELL. We did not collaborate with DAV on our survey. We knew the personal situations that our members were experiencing and we phrased the questions of our survey depending on the experiences that we knew about.

Mr. NYE. Okay. Well, then I would like to ask both of you if you would be willing to share your survey questions so that we might better inform the VA to do some similar outreach on their side?

Mr. COWELL. I cannot imagine that we would not. I think we would need to look at some confidentiality issues with the individual veteran. But maybe there is a way we can scrub that so that the reports are not identifiable.

Mr. NYE. That is fine. I think it is more important that we have the questions and the survey methodology rather than the indi-

vidual names. Mr. Atizado, are you satisfied with that idea as well? With sharing the questions?

Mr. ATIZADO. On the issue about personally identifiable information, I do not see a reason to, I would have to confer with our legal, of course.

Mr. NYE. Okay. Then we will have to follow up with you on that. One more question for Ms. Williams, you had talked during your testimony about erroneous billing for service-connected veterans. Did you also find that there were similar problems with erroneous billing among veterans with non-service-connected injuries.

Ms. WILLIAMS. Yes, we did. With the cases that we followed up, there were cases where they were billed for more than once. And also they were billed for their service-connected disabilities.

Mr. NYE. Great. At this time I would like to yield to the Ranking Member Mr. Brown for any questions he might have.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much. This is kind of a general question, just listening to some of the answers previously. If you are erroneously billed, then you try to correct it. But during the correction stages, they will add penalties on to the bill? And finally, they will actually assess your pension check to be able to make the payment?

Mr. COWELL. That is correct, Congressman Brown.

Mr. BROWN OF SOUTH CAROLINA. They will take it out of your check if you do not pay?

Mr. COWELL. Or they will withhold the amount of money that you may owe the VA for charges being billed.

Mr. ATIZADO. There is a specific process for that, Ranking Member Brown. There is, I believe within so many days, I believe it is 90 days, a certain debt goes to, I believe, the Debt Management Center in——

Mr. BROWN OF SOUTH CAROLINA. Collections center.

Mr. ATIZADO. Well, it actually goes to a debt management, Debt Management Center in Minneapolis. If it is over 180 days it can actually get referred to the offset program that VA has with the Treasury more——

Mr. BROWN OF SOUTH CAROLINA. Do they charge you a fee?

Mr. ATIZADO. I am sorry.

Mr. BROWN OF SOUTH CAROLINA. Do they add a fee on after it is late a certain number of days?

Mr. ATIZADO. I could not speak to that, sir. I do not believe so, but——

Mr. BROWN OF SOUTH CAROLINA. Do they charge you an add on fee if you pay late?

Mr. COWELL. Yes. There is a late penalty and charge for late payment.

Mr. BROWN OF SOUTH CAROLINA. How much does that normally run?

Mr. COWELL. I do not know the——

Mr. BROWN OF SOUTH CAROLINA. It is a percent of the——

Mr. COWELL [continuing]. Percentage, sir, but I could get that information for you.

[Mr. Cowell subsequently provided the following information:]

PVA does not know the methodology that VA used to set the amount of the late penalty fee that has been determined by VA to be an appropriate

amount to be charged. Additionally, PVA does not know just how much lapsed time has been determined by VA to trigger a late payment penalty. Whatever the methodology that VA applied it seems that a case could be made that it was an arbitrary decision by VA and PVA wonders why Congress was not involved in the decision.

Recommendation: PVA suggests that Congressman Brown request information from VA's business office to clarify this question.

Mr. BROWN OF SOUTH CAROLINA. And they will charge you even though that——

Mr. COWELL. Even though the bill is in dispute.

Mr. BROWN OF SOUTH CAROLINA [continuing]. The veteran reports that?

Mr. COWELL. Even though the bill is in dispute, until it is resolved——

Mr. BROWN OF SOUTH CAROLINA. Is that right?

Mr. COWELL [continuing]. The charge continues to accrue.

Mr. BROWN OF SOUTH CAROLINA. And finally, will they just write it off? Of what is the conclusion?

Mr. COWELL. Well, one of the situations that we have heard from our non-service-connected members is if they are not in receipt of a VA pension, so there is not an offset available through withholding compensation or pension, they turn it over to the IRS, who then can, if they have a refund coming on their next year's taxes, they will withhold that refund until that amount is paid.

Mr. BROWN OF SOUTH CAROLINA. If you paid it anyway under protest, will they reimburse it?

Mr. COWELL. I have never known of a case where VA reimbursed for overpayment. I do not think they have a method of even understanding if they are incorrectly billing.

Mr. ATIZADO. They do. Ranking Member, they do. In fact, one of our Members who is the fourth vignette, I believe, in my testimony, did ask for an audit; I believe it was back in March of this year. It was not only until 2 or 3 weeks ago that he received a refund check back. But there is a process, I believe, part of a business integrity policy, a handbook that VA has.

Mr. BROWN OF SOUTH CAROLINA. Okay. Mr. Cowell, let me——

Mr. COWELL. I would just like to add that that burden is on the veteran to even know that he has incorrectly been billed——

Mr. BROWN OF SOUTH CAROLINA. Right.

Mr. COWELL [continuing]. Before he can pursue the remedy for refund.

Mr. BROWN OF SOUTH CAROLINA. Let me ask you a question. You called for VA to take immediate action to change this regulation so that a veteran who is rated permanently and totally can never be erroneously billed. Specifically, what is your recommendation to fix the problem?

Mr. COWELL. You are asking me, Mr. Ranking Member?

Mr. BROWN OF SOUTH CAROLINA. Yes, sir.

Mr. COWELL. Yes. Well, the situation is just so widespread, and we think that each facility, there are liberties being taken with actually the regulation and the statute. If VA cannot clarify the regulation then we would call on Members of Congress to do a statutory change to make it very clear to VA that this is inappropriate.

Mr. BROWN OF SOUTH CAROLINA. Do you think the Administration could do it administratively? Or do you think we would have to take legislative action?

Mr. COWELL. Well, I want to believe that we do not need statutory change. But this has been an ongoing problem. We have mentioned it in *The Independent Budget* for over 2 years. I think because of the language change that happened, and local facilities are able to collect the collections and keep that money, I believe that that has caused a perverse incentive for them to really aggressively go after billing practices. It may take a statutory change to make it absolutely clear so that the VA knows that their boundaries are.

Mr. BROWN OF SOUTH CAROLINA. Okay, thank you. Mr. Cowell, if you could, would you send us a copy of your legislative proposal so that we could then, you know, take some action on it?

Mr. COWELL. I will confer with our legislative director, Mr. Brown, and we will be happy to put some language together for you.

[Mr. Cowell subsequently provided the proposal to the Committee staff.]

> PVA is currently working on a draft proposal to submit to the Committee on Veterans' Affairs regarding billing of veterans with 100 percent a service-connected disability rated Permanent and Total. As we stated in our testimony for the hearing, it makes no sense whatsoever that the VA be permitted to bill a veteran for any care if they have a Permanent and Total rating.
>
> A Total rating suggests that any health condition that requires treatment is secondary to the original service-connected condition without the need for consideration as a second condition. In our opinion, this should mean that 100 percent Total and Permanent service-connected disabled veterans should not be billed, nor should his/her insurance company be billed, for any treatment these veterans receive. Correcting this problem is one of PVA's top legislative priorities for this year. As such, we will be presenting a point paper on the issue of how this change can be implemented either by statute or through regulation.
>
> If veterans who are now rated 100 percent permanent and total are forced to seek adjudication for secondary conditions related to their service-connected condition the VBA claims process will certainly be further swamped by the volume of claims necessary to rectify this situation.

Mr. BROWN OF SOUTH CAROLINA. Very good. Thank you so much.

Mr. NYE. Thank you, Mr. Brown. And thank you to the first panelists. I would like to go ahead and invite the second panel, Ms. Kay Daly, to come up to the table and join us for her testimony.

I would like now to yield to the Subcommittee Chairman, Mr. Michaud.

Mr. MICHAUD [presiding]. First of all, I would like to thank Mr. Nye for taking over and running the Subcommittee hearing for the first panel. I really appreciate it. And I appreciate your advocacy for our veterans. So thank you very much. Ms. Daly.

STATEMENT OF KAY L. DALY, DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. DALY. Mr. Chairman, and Ranking Member Brown, and the other Members of the Subcommittee, I am very pleased to be here today to discuss our prior work on the Department of Veterans Affairs controls over medical center billings and collections.

VA is authorized to provide certain medical services to veterans with non-service-related conditions and to recover some of the costs of providing these additional benefits through billing and collecting payments through veterans' private health insurers. These are commonly referred to as third-party insurers. VA can also use these third-party health insurance collections to supplement its medical care appropriations.

Today, my testimony will summarize the findings from our June 2008 report that are most relevant to the subject of today's hearing. Specifically, I will focus on our findings concerning one, the effectiveness of VA medical center billing practices at selected locations we visited; and two, VA-wide controls for performing timely followup on amounts that were due from third-party insurers; and third, the adequacy of VA's oversight of the billing and collection process.

Regarding the effectiveness of the billing processes, our analysis of unbilled patient services at 18 case study locations found excessive average days to bill, coding and billing errors, and a lack of management oversight that raised questions about $1.7 billion that was not billed to third-party insurers at the 18 locations we reviewed. Now, it is important that coding for the medical services is accurate and timely because insurers will not accept improperly coded bills or bills that are considered late, which is usually 1 year, or sometimes as little as 6 months, after the services were provided.

At the 10 non-Consolidated Patient Account Center (CPAC) medical centers we reviewed, we found the average days to bill ranged from 109 days to 146 days in fiscal year 2007. That compares to VA's goal of 60 days. We also found these centers had significant problems that accounted for over $254 million, that is 21 percent, of the total unbilled medical services cost at those 10 centers.

Now, our case study analysis of the eight medical centers that were under the CPAC initiative found that CPAC officials performed a more thorough review of the billing function. The CPAC centers average days to bill ranged from 39 days to 68 days, and their billing errors accounted for about $37.5 million, or about 7 percent of the medical center costs that were not billed to third-party insurers. Managers at the locations we visited did not perform adequate reviews of the services assigned to the various categories, including whether it was service- or non-service-connected, to ensure that the bills were appropriately coded and classified.

Our June 2008 report also identified significant problems related to timely followup with third-party insurers on their actions to collect amounts that had been billed. Our statistically valid tests for the required initial followup showed a failure rate of 69 percent VA-wide, 36 percent for the CPAC centers and 71 percent for non-CPAC centers. The failure to make timely followup contacts and delays in initiating those contacts with the third-party insurance companies increases the risks that the payments will not be collected, or that payments will be substantially delayed. Management officials at several of the medical centers tested in our statistical sample attributed their high followup failure rate to inadequate staffing. However, we found that a lack of management

oversight at the medical centers, as well as at the VA management level, contribute to the control weaknesses we identified.

In addition, we found that VA and medical centers have few standardized management reports to facilitate the oversight. Limitations in management reporting were because VA's health care billing and collections systems operate as stand alone systems at each medical center. Therefore, VA-wide reporting was dependent on numerous individual queries and data calls. Enhanced oversight would permit VA headquarters and medical center management to monitor trends and performance metrics, such as increases or decreases in unbillable amounts.

In summary, until VA addresses its significant continuing weaknesses in controls over coding, billing, and collections followup, it will continue to be at risk for millions in erroneous billings and not maximize revenue that can provide medical care to our Nation's veterans.

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

[The prepared statement of Ms. Daly appears on p. 35.]

Mr. MICHAUD. Thank you very much, Ms. Daly, for your testimony this morning. Are the internal control issues you identified related to VA billing and collection practices the result of a lack of oversight at the local medical centers? Or is this a VA-wide problem? What can officials at both levels do to fix these problems? What should Congress do?

Ms. DALY. That is a very good question. I think we found there were problems at both the local medical centers in doing adequate oversight over how the bills were being coded and classified, and whether they were being classified correctly so they could be billed correctly. Then VA-wide, we found that they lacked good policies and procedures. There was a significant lack of policies and procedures in place, and they also did not get information in order to provide good oversight over the process, too, at the VA-wide level.

Regarding what Congress could do, I think that Congress has taken some important steps already. Providing hearings such as this today help raise awareness of the issue and helps you in providing oversight. And, of course, GAO always stands ready to help you in performing that oversight in any way you wish.

Mr. MICHAUD. Thank you. And I would like to thank you and all the staff at GAO for the tremendous job that you do in helping Congress, not only this Committee but all the Committees of Congress, do its job. So thank you very much. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. And I also want to echo that, Ms. Daly. I just have one quick question. Given today's testimony, do you see a need for a followup GAO review to determine how multiple and inappropriate billing errors continue to occur, and what action must be taken to prevent future problems?

Ms. DALY. Well, Congressman Brown, I think it would be important, if it is important to the Congress to help you explore these issues further, we would be glad to assist in any way we can. I think there were certain issues that were discussed at today's hear-

ing earlier that was outside of our review's scope. So I, if there is any way we can assist we would be glad to do so.

Mr. BROWN OF SOUTH CAROLINA. Do you see any change in the, I guess, whether it is becoming more errors or less errors? Or what is your handle on that?

Ms. DALY. Well, from our review of June 2008 we have not had the opportunity to follow up on the impact of that yet, and the actions that VA has taken. VA informed us last week that they had issued new policies and procedures and a handbook, but I am not sure how effectively that has been implemented at the medical centers at this time.

Mr. BROWN OF SOUTH CAROLINA. What percentage of billings are third party?

Ms. DALY. I do not have that answer readily available for you, sir, but I would be glad to get back to you with that.

[The GAO subsequently provided the following information:]

> According to VHA's Chief Business Officer, 83 percent of its billings in fiscal year 2009 stem from veterans' private health insurers, commonly referred to as third-party insurers.

Mr. BROWN OF SOUTH CAROLINA. It is a significant number, I assume?

Ms. DALY. I think so. The amounts that we saw at just the 10 medical centers, the way they were classified it looked as though, there were $1.7 billion in total at all of the 18 centers. But I cannot say how much of that was third party or not.

Mr. BROWN OF SOUTH CAROLINA. And what do you do with those funds?

Ms. DALY. I am sorry?

Mr. BROWN OF SOUTH CAROLINA. What do you do with those funds?

Ms. DALY. Those funds can be used, that is, anything recovered from the third-party medical insurers, can be used toward medical care for VA, you know, our veterans.

Mr. BROWN OF SOUTH CAROLINA. Do you all decide that? Or is that decided legislatively?

Ms. DALY. The Congress passed a law permitting that back in, I believe, 1996.

Mr. BROWN OF SOUTH CAROLINA. So that gives you all the flexibility to spend them under different categories? Or do you have a specific purpose to spend it on? Like, could you spend it on buildings? Or equipment? Or is it just for paying employees? Or, you know, how much freedom do you have to use those funds?

Ms. DALY. Well sir, I believe it is supposed to be focused on just the medical care. But I am not certain if it cannot extend to facilities related to medical care or not, so if you would like, I could get back to you with that information.

[The GAO subsequently provided the following information:]

> In our June 2008 report (GAO–08–675), we reported that the Veterans Reconciliation Act 1997, which was enacted as part of the Balanced Budget Act 1997, authorized VA to collect and deposit third-party health insurance payments in its Medical Care Collections Fund, which VA could then use to supplement its medical care appropriations.
>
> Specifically, amounts in that fund can be used for furnishing medical care and services and for VA expenses related to the identification, billing, auditing, and collection of amounts owed.

Mr. BROWN OF SOUTH CAROLINA. Okay. It could be $2 billion or $3 billion, it seems like.

Ms. DALY. That was roughly how much was collected last year from third-party insurers. It was over $2 billion.

Mr. BROWN OF SOUTH CAROLINA. Right. Okay. Thank you very much.

Ms. DALY. Thank you.

Mr. MICHAUD. Mr. Snyder.

Mr. SNYDER. I do not have any questions.

Mr. MICHAUD. Well, once again thank you very much, Ms. Daly, for your testimony this morning. We look forward to working with you as we move forward to get further into this issue. So thank you very much.

Ms. DALY. You are very welcome.

Mr. MICHAUD. I would like to call the third and last panel. It is Mr. Gary Baker, who is the Chief Business Officer of the Veterans Health Administration of the VA, who is accompanied by Ms. Stephanie Mardon and Ms. Kristin Cunningham. I would like to thank you, Mr. Baker, for coming here this morning. We look forward to your testimony, and thank you for all that you do for our veterans.

STATEMENT OF GARY M. BAKER, MA, CHIEF BUSINESS OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY STEPHANIE MARDON, DEPUTY CHIEF BUSINESS OFFICER FOR REVENUE OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KRISTIN CUNNINGHAM, DIRECTOR OF BUSINESS OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. BAKER. Thank you, Mr. Chairman, and Mr. Ranking Member. Thank you for providing me this opportunity to discuss the Department of Veterans Affairs' billing practices. I am accompanied today by Ms. Stephanie Mardon, Deputy Chief Business Officer for Revenue Operations, and Ms. Kristin Cunningham, Director of Business Operations. I would like to request that my written statement be submitted for the record.

Mr. MICHAUD. Without objection, so ordered.

Mr. BAKER. Thank you. VA is required by law to charge copayments to certain veterans who meet income requirements and who receive care for non-service-connected conditions. VA must also bill health insurance carriers for services provided to veterans treated for their non-service-connected conditions. VA currently has four types of non-service-connected copayments for which veterans may be charged: outpatient and inpatient medical services, extended care services, and medication copays. Veterans who are unable to pay VA's copayment charges are encouraged to complete requests for assistance at their local facility. VA earlier embarked on a program this year to improve communication of these options for assistance through posters and other materials posted on VA's Web site and available at local medical centers. Veterans and their families can also call VA's first party call center, as was referenced earlier at the Topeka Health Resource Center, using a toll-free num-

ber for assistance in understanding their copayment charges and payment alternative options.

VA bills health care insurers for non-service-connected conditions. Veterans are not responsible for paying any of the remaining balance of VA's insurance claims that are not paid or covered by their health insurance. Any payment received by VA is used to offset, dollar for dollar, the veteran's copayment responsibility. I might add that it is this dollar for dollar copay offset that delays VA's copay billing as was mentioned earlier in a previous panel.

Veterans and their health insurers are not to be charged for care provided for their service-connected conditions. VA has a number of mechanisms in place to ensure that charges are appropriate. VA's health information system identifies veterans who are service-connected, flags their record, and lists all rated service-connected disabilities. During each treatment encounter the VA provider determines whether the medical care or prescriptions provided are related to the veteran's service-connected disabilities. This prevents bills from being generated automatically. In addition, when VA is notified that a veteran is rated as service-connected retroactively through a service-connected adjudication award, VA automatically reviews the account and refunds are generated back to the effective date of the service-connected decision. If the veteran has not paid the copay then the copay is wiped off the books.

We thank the VSOs for their suggestions on improvements and note the VA has already addressed many of them. As an example, VA has enhanced our VistA information system to facilitate data exchange between Veterans Benefits Administration (VBA) and Veterans Health Administration (VHA) so that medical personnel now have access to up to 150 service-connected conditions, if there are that many rated by VBA. Additionally, medical center staff have access to other computer applications that provide more detailed information on service-connected rated disabilities when that is required. Moreover, VA has already put in place extensive training for staff to appropriately determine service connection and other special authority relationships for billing purposes. I brought with me today an example of our crib cards that are available on the computer terminals for billing staff and providers that provides information on billing activity, appropriate service-connected information, and other issues that relate to the providers' responsibilities as veterans are billed. In addition, business compliance staff at each facility also perform a variety of first and third-party billing compliance reviews that are routinely reported to VHA leadership at local, regional, and national levels.

Over the past 5 years, VHA has also developed many other initiatives to improve billing practices, including publication of a handbook that establishes policies and procedures for monitoring possible inappropriate referrals to the debt management center and Treasury offset program, as were mentioned earlier. Additionally, VA installed software in all systems in 2008 to ensure that these debts were not referred automatically for offset. That is that they require review by billing staff before they are sent to make sure that the offset is appropriate based on the veteran's eligibility status. This has resulted in a dramatic reduction in inappropriate referrals. VA also now requires staff to perform monthly reviews of

medical care billing and report results to local compliance officers. In order to accurately classify care as not billable, VA implemented a software enhancement in July of 2009 in followup to the GAO report that was mentioned earlier. VA also implemented a mechanism to monitor and periodically audit these determinations. Finally, VA strengthened controls over accounts receivable by implementing monitors by Veterans Integrated Service Network quality assurance staff.

Mr. Chairman, we appreciate the opportunity to respond to the concerns about VA's billing practices raised by veterans and oversight bodies, and to describe our efforts to improve these processes. Should a veteran receive a bill that appears to be in error, VA encourages the veteran to contact their local medical center revenue staff who will review the bill with the veteran and help reconcile the issue.

Thank you again for this opportunity. My colleagues and I are available for your questions, sir.

[The prepared statement of Mr. Baker appears on p. 43.]

Mr. MICHAUD. Thank you very much, Mr. Baker, for your testimony. I appreciate what VA has been trying to do to solve this problem. However, as you heard from the first panel, there seems to be a disconnect in looking at billing for a service-connected disability. That is a big concern that I have. At the beginning of the year, we heard through the grapevine that this Administration was going to go after third-party collections for veterans with service-connected disabilities. So I am wondering whether or not there is someone in the VA who still believes that is a good policy and is doing it even though they are not supposed to. There are veterans who will fight this. But unfortunately, then there will be veterans who will not fight it, and will actually pay. That is the big concern that I have. I know that the GAO made seven recommendations on how the VA can correct this. Has the VA adopted all seven of those recommendations?

Mr. BAKER. Yes, Mr. Chairman. VA has provided information to GAO, as we mentioned, at a meeting that was held earlier last week. But we had provided a written response some time ago indicating our actions on all seven activities. And we have incorporated their recommendations into our policies and practice, issued new handbooks, new policy guidelines, and training and followup.

If I might address the service-connected issue, it has never been VA's authority to bill for service-connected conditions. While I understand that there was earlier this year some discussion of changing that practice, that was never communicated to our field facilities and providers as a change in policy. And our information systems, as I indicated earlier, automatically exempt service-connected veterans who are compensably service-connected from copay billing for inpatient and outpatient care, and other exemptions as they relate to eligibility. And our providers received no change in instructions in terms of exempting veterans for treatment of their service-connected conditions. In terms of the concerns that were addressed by the first panel in terms of billing for service-connected conditions, I would not sit here and say that VA is perfect in its billing practices. Certainly there are times when we make errors and we stand ready and willing to correct those errors. And if there are in-

stances where we are not being timely in terms of followup on that, we certainly want to hear about that so that we can improve them not only on an individual situation, but if we have a systemic problem we are more than happy to address that.

However, there was a concern expressed about our billing for conditions that are related to a service-connected condition, whether for 100-percent service-connected veteran who is permanent and total, or any veteran who has a condition that is either secondary to or adjunct to their service-connected condition. The authority for VA to bill for third-party insurance states that VA will bill for non-service-connected conditions. It does not state that VA health care providers are in the business of adjudicating what is or is not a service-connected condition. And it is the legal interpretation that VHA has received from our General Counsel and our policy that we will bill third-party insurers for non-service-connected conditions.

As such a veteran, as was indicated, who is permanently and totally disabled who is service-connected for a particular condition but who has a secondary condition that, while related to that, is not actually adjudicated as service-connected, we at this time have an obligation to bill third-party insurers for that care. Now, obviously, as we indicated earlier, if that veteran is exempt from copays based on their eligibility status, and obviously a 100-percent service-connected veteran is exempt from all copay bills, no copy bills are generated in that situation.

Mr. MICHAUD. Do you view improper billing as a problem? Or do you feel that what you heard from the first panel are just isolated cases?

Mr. BAKER. In terms of improper billing? I think VA billed almost $16 million, or $13 million copay bills last year total. I think that there is a possibility that VA makes errors in making copay bills, or in the millions of third-party bills that we make. I do not believe that we have a large scale systemic problem in terms of identification of service-connected conditions. But it is related to the frontline provider who delivers service, identifying that the care is related or not related to the veteran's service-connected condition. We recognize that there can be occasionally be errors made in that situation, and that there are interpretation issues that can arise particularly related to the issues related to adjunct and secondary conditions, where the veteran clearly thinks that it is related to their service-connected condition. But within a strict interpretation of the law, we are required to bill for non-service-connected care to third-party payers.

Mr. MICHAUD. Are there any regions doing a worse job than others in their improper billing practices? Or is it equalized across the VA system? Or are there some regions that are bad? Or worse, I should say.

Mr. BAKER. In terms of the kind of information that was provided earlier by the first panel, basically we are dependent on the anecdotal information of individual reports that we follow up on when we receive that information. We have not seen a pattern particularly related to geography or individual locations to my knowledge, sir.

Mr. MICHAUD. But you keep a record of the improper billing?

Mr. BAKER. Well, when we are made aware of an improper billing at a national level we do. We do not have a mechanism of aggregating individual requests for reclaim at local facilities. So we do not have a mechanism that aggregates that nationally for review on a regular basis.

Mr. MICHAUD. Do the local facilities keep a record?

Mr. BAKER. I cannot answer that, sir. I do not know whether any of the other panel members know or not. We will take that for the record, sir, and answer that question.

Mr. MICHAUD. Yes, but I would like to see what the error rate has been at the local area, and if you can break that out. I am concerned that there might be some areas that are interpreting the statutes differently. And if so, then billing errors may be really focused in those particular areas. I would assume that since this is an issue that has been raised and with which VSOs have been concerned about, that central office would have taken a more proactive approach in asking, "Well, is this a problem? And if so, is it systemic throughout the VA? Or are there different regions where it is concentrated?" Since it appears that you have not done that, I am just concerned about how much weight you are really putting on the errors out here. Because I can tell you, having heard from veterans who have been billed improperly, that is definitely an emotional and stressful time for those individuals who served this country. So I would like to know whether or not it is a systemic issue, and if you can give a break out of where those cases are throughout the VA system. And if the VSOs have any information on that as well, hopefully the VSOs would be able to bring that to the Committee, also.

[The VA subsequently provided the following information:]

Brief Statement of Issue: On October 15, 2009, the House Veterans' Affairs Committee (HVAC), Subcommittee on Health held a hearing entitled "Inappropriate Billing Practices of the VA: Identifying the Causes and Exploring Potential Solutions." During the hearing, representatives from veterans service organizations expressed concerns on behalf of their members regarding VA's billing for service-connected care. As a followup action item, HVAC Health Chairman Michaud tasked VA with identifying the number of first and third party bills that were issued in error when providing care to service-connected veterans or those with special treatment authorities.

Response: Since the information necessary to respond to this tasker was not available nationally, the Veterans Health Administration (VHA) Chief Business Office (CBO) conducted a data call with field facilities to obtain the information for fiscal year 2009. The results of the data call showed approximately 0.13 percent of all charges for first party billing and 0.08 percent of all third party health insurance claims were canceled due to service-connected or special authority relationship (Attachment 1). In terms of unique veterans, VA estimates that 3,899 had charges canceled for first party bills and 1,182 had bills canceled that were sent to third party health insurance.

Conclusion: VA strives to ensure that all veterans are billed correctly and will provide education to all appropriate VHA staff regarding proper identification of service connected and special authority treatment to ensure bills are not issued in error.

Attachment 1

First Party Charge Information for FY 2009 Related to Cancelled Charges Due to Service Connection or Special Authorities

First Party

	Total No. Charges Billed	Total $$ Billed	Total No. Charges. Cancelled for SC/SA	Total $$. Cancelled for SC/SA	% Charges Cancelled for SC/SA Compared to National	Unique 1st Party Veterans impacted by VISN	% Charges. Cancelled for SC/SA Compared to Total Billed	% of Dollars Cancelled for SC/SA Compared to Total Billed
National Data	58,123,612	$1,098,640,563	75,756	$1,617,598	100.00%	3899	0.13%	0.15%
VISN 1	2,688,063	$53,328,682	2,303	$46,995	3.04%	119	0.09%	0.09%
VISN 2	1,459,129	$27,625,709	3,629	$80,553	4.79%	187	0.25%	0.29%
VISN 3	2,099,330	$39,912,620	2,703	$40,294	3.57%	139	0.13%	0.10%
VISN 4	3,424,203	$66,292,937	2,499	$74,896	3.30%	129	0.07%	0.11%
VISN 5	1,254,997	$23,978,122	431	$7,885	0.57%	22	0.03%	0.03%
VISN 6	3,035,771	$57,577,576	2,972	$69,837	3.92%	153	0.10%	0.12%
VISN 7	3,361,357	$60,447,896	2,342	$44,290	3.09%	121	0.07%	0.07%
VISN 8	5,440,431	$104,456,086	10,148	$170,557	13.40%	522	0.19%	0.16%
VISN 9	2,725,788	$54,098,602	4,256	$111,304	5.62%	219	0.16%	0.21%
VISN 10	2,214,198	$42,735,574	1,672	$30,914	2.21%	86	0.08%	0.07%
VISN 11	2,719,451	$52,282,501	3,685	$90,682	4.86%	190	0.14%	0.17%
VISN 12	3,350,670	$60,497,329	3,089	$62,125	4.08%	159	0.09%	0.10%
VISN 15	2,598,516	$52,952,044	3,640	$72,326	4.80%	187	0.14%	0.14%
VISN 16	5,168,865	$89,658,986	12,951	$238,408	17.10%	667	0.25%	0.27%
VISN 17	2,351,779	$43,216,067	2,266	$38,291	2.99%	117	0.10%	0.09%
VISN 18	2,484,447	$44,879,226	4,371	$138,507	5.77%	225	0.18%	0.31%
VISN 19	1,706,080	$32,857,659	4,176	$88,895	5.51%	215	0.24%	0.27%
VISN 20	1,952,795	$38,959,407	1,984	$52,225	2.62%	102	0.10%	0.13%
VISN 21	2,259,813	$41,638,891	1,732	$26,307	2.29%	89	0.08%	0.06%
VISN 22	2,240,935	$43,783,321	2,265	$57,288	2.99%	117	0.10%	0.13%
VISN 23	3,586,994	$67,461,328	2,642	$75,020	3.49%	136	0.07%	0.11%

Third Party Bill Information for FY 2009 Related to Cancelled Charges Due to Service Connection or Special Authorities

Third Party

	Total No. Bills	Total $$ Billed	Total No. Bills Cancelled for SC/SA	Total $$. Cancelled for SC/SA	% Bills Cancelled for SC/SA vs. National Total	Unique 3rd Party Veterans impacted by VISN	% Bills Cancelled for SC/SA Compared to Total Billed	% of Dollars Cancelled for SC/SA Compared to Total Billed
National Data	15,996,559	$5,262,640,851	13,247	$17,978,532	100.00%	1182	0.08%	0.34%
VISN 1	916,315	$237,694,722	751	$339,155	5.67%	67	0.08%	0.14%
VISN 2	337,687	$64,513,751	43	$116,401	0.32%	4	0.01%	0.18%
VISN 3	761,149	$280,054,567	430	$878,711	3.25%	38	0.06%	0.31%
VISN 4	681,663	$198,947,474	508	$264,083	3.83%	45	0.07%	0.13%
VISN 5	449,432	$99,607,402	209	$265,212	1.58%	19	0.05%	0.27%
VISN 6	1,173,067	$390,049,591	1,197	$1,797,072	9.04%	107	0.10%	0.46%
VISN 7	1,108,811	$324,126,450	1,212	$3,208,808	9.15%	108	0.11%	0.99%
VISN 8	1,479,890	$551,943,794	575	$1,501,974	4.34%	51	0.04%	0.27%
VISN 9	981,260	$327,630,840	624	$577,341	4.71%	56	0.06%	0.18%
VISN 10	650,447	$207,057,364	540	$289,590	4.08%	48	0.08%	0.14%
VISN 11	747,082	$196,937,482	35	$1,932	0.26%	3	0.00%	0.00%
VISN 12	635,279	$264,870,793	429	$3,023,688	3.24%	38	0.07%	1.14%
VISN 15	597,016	$160,827,421	750	$992,605	5.66%	67	0.13%	0.62%
VISN 16	1,300,072	$411,264,979	2,701	$650,849	20.39%	241	0.21%	0.16%
VISN 17	611,718	$195,039,564	244	$89,430	1.84%	22	0.04%	0.05%
VISN 18	642,145	$246,543,368	523	$1,094,209	3.95%	47	0.08%	0.44%
VISN 19	490,095	$155,538,544	804	$932,032	6.07%	72	0.16%	0.60%
VISN 20	524,931	$203,956,161	756	$833,731	5.71%	67	0.14%	0.41%
VISN 21	420,452	$217,609,364	278	$523,269	2.10%	25	0.07%	0.24%
VISN 22	348,832	$186,329,272	192	$228,661	1.45%	17	0.06%	0.12%
VISN 23	1,139,216	$342,097,949	446	$369,782	3.37%	40	0.04%	0.11%

Mr. BAKER. Yes, sir. I would mention that within the past year we have had three, what we call table topic training sessions, for nationally, on the issue of service-connected billing, both copay and third party, to provide training to our staff in the field on what is sometimes a difficult situation. So certainly we are aware of the concern, and we have tried to take action both in terms of training and policy to address this issue.

Mr. MICHAUD. Because the only way I would see improper billing would be if you decided to bill Medicare for their services——

Mr. BAKER. As you know, we are precluded from doing that, sir.

Mr. MICHAUD. I know. But if you have to do improper billing——

Mr. BAKER. That is where we should——

Mr. MICHAUD. That is the way you should do the improper billing versus the improper billing for our veterans. Mr. Brown?

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. Thank you, Mr. Baker, for your service. I know those 16 million claims that you pay a year, we probably never hear from all the millions that it works okay. But, you know, that is the way the system works, right? You hear from those that it is not connecting. My question would be is that, we heard from the veterans service organizations that say they do not receive their billing statements from VA until several months after the service. Could you address that timeline?

Mr. BAKER. Yes. We have——

Mr. BROWN OF SOUTH CAROLINA. They said it could be as much as 3 months.

Mr. BAKER. Right. We have a mechanism that we hold the first party copay bills if a veteran has third-party insurance.

Mr. BROWN OF SOUTH CAROLINA. To be sure you collect it?

Mr. BAKER. To allow us to submit the bill to the third-party insurer and give them an opportunity to pay. So that if there is a payment from the third-party insurance that covers the entire copay or portion of it, that we would only bill that remainder. That does delay our release of the copay bill to the individual veteran for 90 days. If we have not received payment or receive only partial payment, then the copay bill is released after that 90-day period. And it is an issue, also, that we do process those insurance claims and apply them to our copay bills through a manual process rather than an automated process. So it does take some time to do that. And there are potentials for error based on that manual process. But certainly we have worked hard to educate and improve our processes in that area. It is part of our response to concerns that were expressed by an OIG report back in 2004 that identified some problems in this area.

Mr. BROWN OF SOUTH CAROLINA. Do you have just a normal chain of command to these guys that really have a problem addressing the bills? Do we have some kind of an organization set up so they do not fall through the loops? I know that sometimes they said that even under the protest, you know, they get some kind of add on service charge because they are late.

Mr. BAKER. Well to address the service charge, there is an administration and interest charge that occurs for copays that remain on the books over a certain period of time and they do aggregate every 30 days. We have a number of mechanisms that are available

to assist the veterans who have questions or concerns. We certainly have revenue staff at individual facilities that are available. We have patient advocate staff that are available to assist the veterans. We have our national First Party Call Center that was established specifically because when copay bills are sent we often receive a flurry of calls based on those copay bills. And that was creating difficulties at local sites. So we created our Health Resource Center in Topeka, Kansas, which focuses specifically on that. They have the copay bills available and they have information that allows them access to each individual VistA system across the system so they can review the copay bill with the veteran, look at what care was provided, and help explain to the veteran what the conditions may be.

As was indicated during the first panel, there are situations where it cannot be resolved through the First Party Call Center and it requires a review by the local facility. But we have worked hard to improve our handoff process for that to make sure that there is followup on that and our call center does follow up periodically to make sure that the condition has been addressed and the veteran has received a response to his inquiry.

Mr. BROWN OF SOUTH CAROLINA. Do you have, like, a special person designated at each one of the service centers to address delinquent accounts?

Mr. BAKER. We have accounts receivable technicians who are responsible for followup on third-party claims, as was identified during the GAO testimony. But they also followup on first party claims as well.

Mr. BROWN OF SOUTH CAROLINA. I guess you heard from the gentleman from the PVA who calls for the VA to take immediate action to change its regulation so that veterans rated permanently and totally could never have been erroneously billed. Specifically, what can be done to fix the problem? And do we need legislation to address it?

Mr. BAKER. My understanding of the current law as written is that VA is responsible for billing for non-service-connected conditions. Permanent and total veterans can receive care for both their service-connected and for non-service-connected conditions that have not been adjudicated. It was an important point, I think, that was made by the first panel that this policy requires that in those circumstances that the veteran wants to avoid that billing to their third-party insurance company that they be required to submit a claim for service-connection. And if that does not provide a particular value to the veteran, other than avoiding third-party billing, it certainly does create additional work for VA. So my assessment would be that if this is a concern to Congress and the veteran community, that it require legislation for VA to change its practices.

Mr. BROWN OF SOUTH CAROLINA. But let me ask you a question, Mr. Baker. If they do not want you to bill the third party, why are they giving you the third-party information?

Mr. BAKER. We ask veterans to provide us with third-party information so that we can meet our requirement to bill for non-service-connected——

Mr. BROWN OF SOUTH CAROLINA. But if it is 100-percent disabled, why would you even need it?

Mr. BAKER. Well, this is a supposition on my part, sir. It is hard for me to know specifically what happens in every circumstance. But I think even in cases where veterans are 100-percent service-connected and permanently and totally disabled, there is a recognition of a difference between a condition that has no relationship to their service-connected disabilities, and one that they think is secondary or adjunct to that condition. And it is in those situations where they believe that it is secondary to or caused by their service-connected condition that the veterans are asserting that it is inappropriate for VA to bill for that care.

Mr. BROWN OF SOUTH CAROLINA. Okay, just one further question. I know that we are going to have to go vote, and thank you for your patience, Mr. Chairman. But do you feel like you have a pretty good cross sharing of information between the VBA and the VHA?

Mr. BAKER. We have worked hard to improve our situation in sharing information with VBA and VHA. VHA has always had the ability to store a virtually unlimited number of service-connected conditions. However, the information system used by VBA in the past could only store six conditions. As VBA has moved to its VETSNET system, the corporate information system, they are now able to store an unlimited number of service-connected conditions as well. It is my understanding that for any condition that, or any veteran who has had a rating decision since 2002, that their new corporate information system has all service-connected disabilities. We have linked our VHA information system with them. And when we established that initial link we also went back for all known service-connected veterans who were in the VHA information system at that time and queried VBA to get that full range of service-connected information rather than just the six that we might have previously. For any new adjudication actions, either new or updated, we automatically receive the full range of service-connected conditions at this time. It flows through our enrollment information system and goes to each individual VistA system. So it is available to providers, billing staff, and eligibility staff at every medical center.

Mr. BROWN OF SOUTH CAROLINA. Just for curiosity, how large is that data file?

Mr. BAKER. The data file has information on approximately 9 million veterans, 7.6 million of which are active enrolled veterans at this time.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much.

Mr. MICHAUD. Thank you very much, Mr. Brown. Once again, Mr. Baker, I want to thank you, and Ms. Mardon, and Ms. Cunningham for coming here this morning. I look forward to working with you as we move forward to try to take care of some of the problems that we heard from the first panel. And I also want to thank all the VA staff. I know it is not an easy job and all too often we tend to forget to thank those who are actually administering and doing what they have to do to make sure the veterans are served. So thank you and your staff for what you are doing.

Mr. BAKER. Thank you, sir.

Mr. MICHAUD. The hearing is adjourned.

[Whereupon, at 11:17 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I would like to thank everyone for attending this hearing.

Today's hearing will focus on the inappropriate billing practices of the VA where veterans receive a bill for the wrong amount or get a bill that they should not have received in the first place. Unfortunately, inappropriate billing affects both service-connected veterans and non-service connected veterans.

For example, a veteran with a service-related spinal cord injury may be billed for the treatment of urinary tract infections. Urinary tract infection is clearly linked to and is a result of the service-connected injury; however, these veterans are receiving bills for the treatment of such secondary conditions. As a result, these veterans may be forced to seek a time-consuming and burdensome readjudication of their claims indicating the original service-connected ratings.

It is my understanding that one of the reasons for inappropriate billing of secondary conditions is that the VA cannot store more than six service connected conditions in their IT system. It is also my understanding that the VA is taking steps to correct this deficiency, but the problem has not been fully resolved and our veterans continue to receive the inaccurate bills.

Non-service connected veterans also encounter overbilling and inappropriate charges for copayments. One issue that I've been made aware of repeatedly is that some non-service connected veterans receive multiple bills for a single medical treatment or health care visit. It is evident that inefficiencies in the billing system exist where something is inappropriately triggering the multiple billing episodes.

It may be simple human error or IT error, but this has the potential of imposing an unnecessary burden on our veterans. Just imagine all the time that our veterans spend and the stress that they experience in trying to resolve the improper bills. One thing is clear. Inappropriate billing is not acceptable and we must do better by our veterans.

Today, I hope to get to the bottom of this issue. We will examine why veterans and their insurers are receiving inaccurate bills, learn what the VA is doing to address this problem, and explore how we can fully remedy this problem.

We have brought together witnesses who can shed light on this problem, and I look forward to their testimonies.

Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you Mr. Chairman. I appreciate your holding this hearing today.

It is the solemn mission of the Department of Veterans Affairs (VA) and the Federal Government to care for the men and women in uniform who sustain injuries and illnesses as a result of their service to our Nation.

Therefore, I find it deeply troubling to hear about veterans being inappropriately billed for copayments for medical care and medications to treat service connected conditions.

A similar issue arose earlier this year when the Obama Administration was considering a plan to bill veterans' private insurance for service-connected care. Fortunately, this ill-conceived proposal never saw the light of day, given the fierce opposition of members from both sides of the aisle and Veterans Service Organizations.

As I said then, this flies in the face of our moral obligation as a grateful nation to care for these wounded heroes.

I continue to strongly oppose any attempt to allow VA to shirk this obligation and will ensure that we uphold our responsibility to provide resources to protect and honor the service of our highest priority veterans.

It is unacceptable for VA not to have and put in force policies and procedures to ensure that veterans are not frustrated and burdened by receiving inappropriate and multiple billing statements.

I look forward to hearing from our witnesses today to gain a better understanding of the depth of the problem and what actions must be taken to prevent future inappropriate billing errors.

Thank you Mr. Chairman. I yield back the balance of my time.

Prepared Statement of Fred Cowell, Senior Health Policy Analyst, Paralyzed Veterans of America

Chairman Michaud, Ranking Member Brown, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to provide testimony on an issue that has had a critical impact on the lives of our members, veterans with spinal cord injury or dysfunction. In recent years, as we have seen significant increases in both medical care collections estimates as well as the actual dollars collected, we have received an increasing number of reports from veterans who are being inappropriately billed by the Veterans Health Administration (VHA) for their care. Moreover, this is not a problem being experienced by just service-connected disabled veterans, but non-service connected disabled veterans as well.

The Independent Budget (IB)—co-authored by PVA, AMVETS, Disabled American Veterans, and Veterans of Foreign Wars—has repeatedly focused our attention on this issue. Unfortunately, until now, little attention has been paid to this problem while medical care collections continue to grow at an alarming rate. We are very pleased that the Subcommittee has chosen to investigate this issue in light of recent budget increases that have included billions of dollars in collections.

Inappropriate charges for VA medical services places unnecessary financial stress on individual veterans and their families. These inaccurate charges are not easily remedied and their occurrence places the burden for correction directly on the veteran, their families or caregivers. PVA believes that many veterans are not aware of these mistakes and simply submit full payment to VA when a billing statement arrives at their home.

Veterans who are astute enough to scrutinize their VA billing statements to identify erroneous charges have just begun a cumbersome process to actually correct the problem and receive a credit for the error on a VA subsequent billing statement. It has become the veteran's responsibility to seek VA assistance wherever possible. This is not an easy task for veterans as VA billing statements are often received months after an actual medical care encounter and subsequent credit corrections only appear months after corrective intervention has taken place. It is often difficult for veterans to remember medical care treatment dates and match billing statements that arrive months after treatment to search for billing errors.

In order to understand inappropriate billing, it is important to emphasize that service-connected and non-service connected veterans have experienced this problem. However, the problems that these two populations of veterans have faced are uniquely different. Service-connected veterans are faced with a scenario where they, or their insurance company, may be billed for treatment of a service-connected condition. Meanwhile, non-service connected disabled veterans are usually billed multiple times for the same treatment episode or have difficulty getting their insurance companies to pay for treatment provided by the VA.

In preparation for this hearing, PVA conducted an email survey of our members. We sent a questionnaire to approximately 4,000 PVA members. Of that number, approximately 10 percent (449 members) of the survey recipients responded. The survey included only a few questions to attempt to gauge the prevalence of billing issues faced by our members. Approximately 30 percent of respondents are either billed directly by the VA for care that they receive or have their insurance companies billed for their care.

After establishing this baseline of information, we directed our questions toward the billing issues that these individuals face. Of the 449 respondents, approximately 9 percent claim to receive more than one bill for the same treatment episode, approximately 17 percent claim to be billed directly for treatment of a service-connected condition, and approximately 22 percent claim that their insurance company is being billed for treatment of a service-connected condition.

Subsequent to this survey, we reached out to our National service officers to help us identify why these issues may be occurring. First, it is important to note that the vast majority of PVA members who are service-connected are rated as 100 percent TOTAL and PERMANENT. To be clear, TOTAL and PERMANENT suggests to us that any condition that a veteran experiences is related to his or her service-connected condition. In our opinion, this should mean that 100 percent TOTAL and PERMANENT service-connected disabled veterans should not be billed, nor should their insurance company be billed, for any treatment they receive. However, this is not how the VHA sees it.

In order to illustrate what we identified as the single biggest billing problem facing our service-connected members, I would like to provide an example. A PVA national service officer is assisting a 100 percent TOTAL and PERMANENT veteran who was injured while serving in Operation Iraqi Freedom (OIF). The veteran also served in Operation Enduring Freedom (OEF). According to the VA medical center where he is receiving care, he has service-connected rating determinations for loss of use of both feet (100 percent), impairment of sphincter control (100 percent), neurogenic bladder (60 percent), traumatic chest wall defect (10 percent), and deformity of the penis (0 percent).

The veteran developed a pressure ulcer on his buttocks. He received bills from the VA on more than one occasion for treatments of the pressure ulcer. The PVA service officer discussed this issue with the Chief of Spinal Cord Medicine at the VA medical center. The doctor then inquired with the billing office at that VA medical center as to why the veteran was being billed for these treatments. He explained that pressure ulcer is the number 1 secondary condition that veterans with spinal cord injury face. The billing office then informed him that he was not rated for that secondary condition; therefore, the facility was permitted to bill for that treatment. More troublesome is that the billing office advised the doctor that if the veteran does not want to be billed for that treatment in the future, he should re-file his compensation claim for consideration of his currently non-rated secondary conditions.

This scenario is unbelievable in so many ways. First and foremost, I go back to my point that veterans who are rated TOTAL and PERMANENT should not be billed for any treatment since TOTAL suggests that any secondary condition is related to the service-connected condition. Second, it is incredible that the VA would suggest that veterans who are being rated for well-known, but non-rated, secondary conditions should re-file or reopen their claims. This is something that we have heard from many of our members and service officers. If the VA thinks it has a problem with the claims backlog now, we can only imagine what the backlog will look like if all veterans experiencing this problem go back to the Veterans Benefits Administration (VBA) for consideration of something that will almost certainly be granted months later.

We would like to recommend that either the VA immediately change its regulations to reflect the fact that a TOTAL and PERMANENT rating means exactly that. If the VA is unwilling to make this absolutely necessary change, then we call on Congress to fix this statutorily.

It is time that the VA stops playing this game. The obvious disconnect between rated service-connected conditions and coding for the purposes of medical care billing is appalling. More astounding is the fact that veterans with more than six service-connected disability ratings are frequently billed improperly due to VA's inability to electronically store more than six service-connected conditions in the Compensation and Pension (C&P) Benefits Delivery Network (BDN) master record. Moreover, the lack of timely and/or complete information exchange about service-connected conditions between the VBA and VHA places an additional burden on the veteran to sort out this disconnect.

VA has undertaken a five-step approach to change the process by which it electronically shares C&P eligibility and benefits data with VHA, particularly information about service-connected conditions that exceed the six stored in the C&P BDN. According to VA, because of difficulties in the development and implementation of the first two steps, the plan for improving VBA/VHA sharing of information about veterans' service-connected conditions has been delayed. Furthermore, VA acknowledges that not all these cases, with six service-connected conditions, have been identified under the new plan; however, it will determine the best course of action to take to further address the cases with incomplete service-connected disability information.

While it is shameful that VHA takes advantage of veterans with service-connected conditions like this, it is equally disappointing that veterans who depend on the VA for their care but who are not rated for service-connected conditions are also being taken advantage of. Non-service connected veterans are also constantly frustrated with VA's billing process. Over-billing and inappropriate charging for copayments is

becoming the norm rather than the exception. Frequently, veterans are experiencing multiple billing episodes for a single medical treatment or health care visit.

Inappropriate bill coding is causing major problems for veterans subject to VA copayments. Veterans using VA specialized services, outpatient services and VA's Home Based Primary Care programs are reporting multiple billings for a single visit. Often these multiple billing instances are the result of followup medical team meetings where a veteran's condition and treatment plan is discussed. Somehow these discussions and subsequent entries into the veteran's medical chart trigger additional billing. In other instances simple phone calls from VA health care professionals to individual veterans to discuss their treatment plan or medication usage can also result in copayment charges when no actual medical visit has even occurred.

Once the veteran has identified a billing error the corrective process just begins. If the error is discovered by the veteran, finding proper assistance is difficult and corrective action takes months to achieve. Corrective action follow thru is the veteran's responsibility because the veteran receives no acknowledgement letter from VA that an error has happened. The veteran is forced to review subsequent billing statements to see if he or she actually receives a credit entry for the previous error.

This is a problem that I have personally experienced. Very often, I receive bills from the Washington, DC, VA medical center that reflect multiple charges for the same treatment episode. On more than one occasion I have even paid out of my own pocket for bills due to the extensive delay in correcting this problem and due to the fact that I have received threatening letters from the VHA about my non-payment. Fortunately, with the help of my direct health care providers and staff at the DC VA, I have been able to eventually resolve these problems. Unfortunately, due to the delays in receiving bills in the first place—usually 3 to 4 months—and the time it takes to remedy this problem—usually an additional 2 to 3 months—I am typically not reimbursed for any payments that I make for that treatment episode for quite some time.

Mr. Chairman and Members of the Subcommittee, it is time that the VA really be taken to task for its billing practices. If Congress and the Administration are going to continue to rely on massive collections estimates and dollars actually collected to support the VA health care budget, then serious examination of how the VA is achieving these numbers is necessary. As long as we know that the VA is taking advantage of veterans and inappropriately billing them, both service-connected and non-service connected, we will continue to express opposition to building VA budgets on collections.

Mr. Chairman, we thank you again for conducting this extremely important hearing. Hopefully through the information provided here, the VA will take corrective action to ensure that veterans are not being burdened with paying medical treatment bills that they should not be paying. We look forward to working with you and the Subcommittee to ensure that these problems get corrected.

Thank you again, and I would be happy to answer any questions that you might have.

Prepared Statement of Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to present our views before the Subcommittee on Health on inappropriate billing practices by the Department of Veterans Affairs (VA). DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to building better lives for disabled veterans and their families. We appreciate your leadership in enhancing VA health care programs on which many service-connected disabled veterans must rely.

As this Subcommittee is aware, the VA has the authority to retain in the Medical Care Collections Fund (MCCF), all collections from health insurers of veterans who receive VA care for non-service-connected conditions, as well as other revenues such as veterans' copayments and deductibles. However, the funds collected may only be used for providing VA medical care and services, and for paying Departmental expenses from the collections. MCCF funds are transferred to a no-year Medical Care service account [1] and allocated to the medical centers that collect them one month in arrears.

[1] P.L. 105–65

Legislative Authority

Authority for the Department to seek reimbursement from third-party health insurers for the cost of medical care furnished to insured non-service-connected veterans, was provided in Public Law 99–272. This law also authorized the VA to assess a means test, based on a veteran's income and assets, for assessing copayment requirements for certain non-service-connected veterans. In 1990, Public Law 101–508 expanded the VA's recovery program by providing authority to seek reimbursement from third-party payers for the cost of medical care provided to insured service-connected veterans who are treated for non-service-connected conditions. The law also authorized the outpatient per diem copayment and medication copayment programs.

In 1997, Public Law 105–33 established the MCCF, and authorized the VA to retain collections from health insurers and veterans' copayments at the local medical center, rather than returned to the Department of Treasury. This law also granted the VA authority to begin billing a veteran's health insurer reasonable charges, which are based on amounts that health insurers pay private sector health care providers for services. Public Law 106–117, enacted in 1999, authorized the VA to set outpatient and medication copayments rates and to establish a maximum cap on medication copayments for a calendar year. This law also authorized the Secretary to establish extended care copayment amounts, a maximum monthly copayment cap and a process to determine an individual veteran's copayment responsibilities based on a veteran's available resources. Public Law 108–7, Public Law 108–422, and Public Law 108–447, consolidated balances and future receipts from other sources into the MCCF and became effective beginning in fiscal year (FY) 2004.

Medical Care Collections

The Veterans Health Administration (VHA) is funded through multiple appropriations accounts that are supplemented by other sources of revenue. The Committees on Veterans' Affairs, in their views and estimates, and the Committees on Appropriations, include MCCF collections when considering the amount of needed funding for the VA's medical care accounts. Consequently, the efficient and timely collection of reimbursable costs is a tremendous driver at local VA facilities that greatly benefits them in meeting growing health care demands. The issue we raise here is the unintended consequences this financial incentive may be having on veterans who seek care from the VA.

Looking at collection estimates from the VA's budget submissions, it should be noted from the table below, that both the adjustment for FY 2006 and slower rate of increase for estimated collections, has contributed to the VA's meeting and exceeding expected collections. However, more than doubling collection estimates from FY 2009 to 2010 may be overly optimistic.

Increase/*(Decrease)* from Previous Fiscal Year
MCCF Budget Estimate

FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
$1,616,619	$2,144,409	$2,418,700	$2,164,004	$2,247,353	$2,320,069	$2,466,860	$2,833,762
	33%	**13%**	***(12%)***	**4%**	**3%**	**6%**	**15%**

Four MCCF subaccounts relevant to this hearing make up over 97 percent of total collections: Third Party; Pharmacy Copayments; First-Party and Other Copayments; and Long-Term Care Copayments. As previously mentioned, the FY 2009 and 2010 budget estimates showing the dramatic increase in estimated collections are to come from Third Party and First Party and Other Copayments.

Increase/*(Decrease)* from Previous Fiscal Year
MCCF Budget Estimate by Subaccount

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
Third Party	$349,018	*$(72,347)*	$138,625	$128,803	*$(49,835)*	$184,154	$443,738
Pharmacy Copays	***$(42,377)***	$311,610	***$(147,210)***	$34,500	$107,125	***$(95,714)***	***$(64,435)***
First-Party & Other Copays	$229,249	$46,100	$***(269,948)***	$***(16,176)***	$18,201	$16,688	$26,445
Long-Term Care Copays	$***(12,151)***	$***(12,153)***	*$(8,500)*	$5,704	*$(1,857)*	$—	$***(456)***
Total	**$523,739**	**$273,210**	***$(287,033)***	**$152,831**	**$73,634**	**$105,128**	**$405,292**

Such expectations in increased collections translate to financial pressure at local facilities to increase their collection efforts. However, the actual-to-expected collections have historically been below the estimated amount, except for FY 2008 when the VA exceeded estimated collections.

Actual vs. Budget Estimate: Gain/*(Loss)*
(in thousands)

	2004	2005	2006	2007	2008
MCCF Budget Estimate	$2,144,409	$2,418,700	$2,133,744	$2,247,353	$2,320,069
MCCF Actual Collections:	$1,747,276	$1,897,089	$2,007,377	$2,226,653	$2,477,880
Total	***$(397,133)***	***$(521,611)***	***$(126,367)***	***$(20,700)***	**$157,811**

For the four relevant sources of revenue, the VA's actual collections substantially exceeded estimates in Third-Party and First-Party and Other Copays, but with substantial losses in other accounts.

Actual vs. Budget Estimate: Gain/*(Loss)*
(in thousands)

MCCF Accounts	2004	2005	2006	2007	2008
Third Party	*$(149,171)*	$ 18,597	*$(79,815)*	*$(43,082)*	$ 242,856
Pharmacy Copayments	$ 14,615	*$(272,006)*	*$(49,973)*	*$(46,884)*	*$(164,940)*
First-Party & Other Copays	*$(246,022)*	*$(287,374)*	*$(477)*	$31,088	$30,197
Long-Term Care Copays	*$(16,076)*	*$(3,589)*	$3,847	*$(2,505)*	*$(596)*
Total	***$(396,654)***	***$ (544,372)***	***$(126,418)***	***$ (61,383)***	**$107,517**

Although it is mitigated to some extent by designating collections as no-year funds, such an exceedingly dramatic shift in gains and losses from which VA medical centers project, plan, and manage health delivery until actual appropriations are received, can have a detrimental effect on meeting the medical care needs of veterans. We are also concerned with the need of local VA facilities to meet ever-increasing budget estimates to ensure adequate funding, may encourage or contribute to inappropriate billing. Hence, the question remains, as to the extent of any cause and effect inappropriate billing and collections may have on the delivery of high quality health care to disabled veterans.

First-Party Billing and Collection

VA's authority for first-party billing under title 38, United States Code, Sections 1710, 1710B, 1722, and 1722A, is in this instance, for first-party copayments assessed against veterans for pharmacy, long-term care, inpatient and outpatient services. MCCF program staff at VA medical facilities establish first-party debts, and to do so accurately, must have valid compensation and pension (C&P) benefit award status information for each veteran receiving medical services to ensure only appropriate billings and collections are made. Disputed bills are normally resolved locally or are otherwise considered delinquent after 3 monthly collection letters are sent by the medical facility to the veteran. Delinquent first-party debts can be sent to a collection agency, or automatically collected under the Treasury Offset Program (TOP), where veterans' Federal payments such as Social Security, VA Compensation, VA Pension, and Internal Revenue Service tax refunds can be offset to collect unpaid delinquent first party debts.

The VA Office of Inspector General (OIG) issued a report[2] on December 1, 2004, evaluating first-party billings and collections only for veterans service-connected 50 percent or higher or in receipt of pension. Four recommendations were made as a consequence of this report. Part of VA's response is an action plan requiring the Of-

[2] http://www.va.gov/oig/52/reports/2005/VAOIG-03-00940-38.pdf

fice of Compliance and Business Integrity (CBI) to monitor copayment charges issued to certain veterans[3] and for facility revenue and the associated business office staff to take corrective action when inappropriate bills are identified. Unfortunately, these corrective measures only apply to those veterans whose compensation and pension have been offset by the inappropriately billed amount—a necessary but high threshold for action by the VA for a problem the Department itself has created.

Despite VA efforts, we receive recurring reports from our members that inappropriate billing continues. Inappropriate billing of veterans for VA medical care occurs due to incorrect C&P status of a veteran, such as the limited number of service-connected disabilities available for MCCF staff to view in their information system, and the effective date of claims for service connection, which were pending when the veteran sought treatment, and thus was made subject to copayments. Clearly, information management is crucial in avoiding inappropriate first-party billing, where such simple information is readily available in the Veterans Benefits Administration (VBA) information system, but may not be readily accessible by the MCCF staff of a local VHA facility. The VA has made little progress linking these two systems for more accurate results.

Third-Party Billing and Collection

Although the VA has attempted to implement more effective billing practices and systems, it has historically been unable to meet its collection goals. Similar to the need to have accurate information on C&P status of veterans, third-party insurance information is also needed to avert inappropriate third-party billing. The type of policies and the types of services covered by the insurers, patient copayments and deductibles, and preadmission certification requirements are vital to the VA's MCCF program. The Department's ability to accurately document the non-service-connected care provided to insured veterans, and assign the appropriate codes for billing purposes, is essential to accurate third-party collections.

Failure to properly document care can lead to missed opportunities to bill for care, billing backlogs, overpayments by insurers, or denials of VA invoices. More importantly, although the VA is authorized to bill third parties only for non-service-connected care, we continue to hear reports from service-connected disabled veterans, their spouses, or caregivers, that the VA is billing their insurance companies for treatment of service-connected conditions. At times, notification of the billing departments of their local VA medical centers is sufficient. In other instances however, the inappropriate billing continues for the same condition or treatment, the inappropriate invoice has been outstanding for such a period of time that the veteran's credit history is adversely impacted through collection agency action, or debt considered 180 days delinquent from inappropriate billing is recovered by automatically offsetting a veteran's compensation or pension benefit[4] causing undue stress on veterans and their families.

To supplement the anecdotal evidence we have collected over the years, DAV recently conducted a survey by email of our DAV Commander's Action Network. We asked survey recipients to participate if they believe VA has inappropriately billed them or their insurance companies. The results of the survey of 402 respondents from across the nation show 43 percent (172 veterans) receive bills for their care from the VA and approximately 62 percent (246) had other insurance coverage being billed for their care at the VA. We also asked if they had received more than one bill for the same treatment for which 18 percent (74) affirmed.

In addition, 42 percent (167) said they are being billed for treatment at the VA for a service-connected condition and 55 percent (220) acknowledged that their insurance companies are being billed for treatment from VA of a service-connected condition.

Of the 281 respondents who provided information for any followup we may have, we selected and contacted four veterans who gladly shared their experiences:

> Veteran from Massachusetts: Service-connected for spinal cord injury (SCI) and was referred to a VA Podiatrist by his primary care physician for a secondary condition related to his SCI. After completing the referral, the veteran's insurance was billed. He spoke to a VA financial officer about this situation. He took no corrective action, but rather responded to the veteran, "your injury is for your back, not your feet! What does it matter to you? You are not paying it, your insurance company is."

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[3] Department of Veterans Affairs, VHA Handbook 1030.03, October 16, 2006.

[4] VA Handbook 4800.7, Treasury Offset Program and Treasury Cross Servicing, December 8, 2003.

Veteran from Wisconsin: Service-connected for degenerative joint disease for which he received care from orthopedics at his local VA medical center. His insurance was billed and subsequently paid a portion for this care. The veteran also paid for his portion of the bill. According to the veteran, inappropriate billings for these treatments have been going on for the past 3 years, despite earlier attempts to correct the situation. The veteran has since decided to let it go unaddressed. According to him, "there is very little discrimination from VA to bill my insurance."

Veteran from North Dakota: Service-connected for hypertension and has an ongoing VA prescription for this condition. He indicates that on and off for well over 2 years, the VA has on more than one occasion billed his insurance for his hypertension medication. Although he has spoken to the business office of his local VA facility, the situation remains unresolved and has left him with the impression that, "they just don't seem to take any corrective action whatsoever."

Veteran from South Carolina: Service-connected for migraine headaches, depression, and orthopedic conditions for which he takes prescription medications from the VA. He had been billed for medication copayments as well as his insurance for medications and treatments for his service-connected disabilities. The veteran would routinely call the toll-free number listed on the bill for medication copayments three to four times a year for corrective action, to no avail. He faxed a copy of his most recent VBA decision, but the inappropriate billing still continued. Consequently, the veteran went to the VA facility in person and handed a copy of his VBA decision to the clerk. Although they were apologetic as the veteran watched the billing staff input the pertinent information, the veteran continues to this day, to receive bills for treatment of his service-connected conditions. He subsequently called to have these bills stopped and asked for an audit in March 2009 for all inappropriate bills that VA has received payment. He finally received his refund early this month. Since then however, the veteran has sporadically received inappropriate bills and has not had the inclination to see if his insurance has paid any inappropriate billing from the VA. His final thought was that, "there are not enough protections in place in the front end and veterans have to pay for their mistakes in the back end."

Mr. Chairman, it should be noted that for those veterans whose inappropriate billing issues were not properly addressed locally, and thus have risen to my office for assistance, the Chief Business Office staff in VA Central Office have been accommodating and expeditious in their assistance on every case. However, this should not be the process for properly addressing all inappropriate billing cases.

Our members believe asking veterans to pay for part of the benefits a grateful nation provides for them is fundamentally contrary to the spirit and principles underlying the provision of benefits to veterans. Accordingly, the delegates of our most recent national convention held in Denver, Colorado August 22–25, 2009, passed two pertinent resolutions: Resolution No. 234, which calls for legislation to repeal all copayments for military retirees' and veterans' medical services and prescriptions; and Resolution No. 184, which opposes any legislation that would require the VA to recover third-party payments for the care and treatment of a veteran's service-connected disabilities.

The VA should be credited for actions it has taken for collecting accurate first- and third-party information, strengthening coding procedures and medical record documentation, which is aimed at enhancing revenue collections and protecting against inappropriate billing. However, the current revenue process requires extensive manual and subjective intervention, causing significant delays in collections and diminished revenue for the VHA. It also results in inappropriate billing to veterans and their insurers, and places undue burden and stress of veterans and their families. While under the law, VA must bill veterans and their insurers for providing treatment for non-service-connected conditions. Causing harm in the process requires the Department to be more proactive to redress such actions and ensure no repetition occurs. As our survey reveals, whatever system or process the VA is using to address inappropriate billing, much work still needs to be done.

We look forward to hearing from VA today on what it is proactively doing to find and correct inappropriate bills and to eliminate future inappropriate billing to veterans and their insurers. In addition, we are interested to hear more about how the VHA's Revenue Improvement and Systems Enhancements (RISE) program and Consolidated Patient Account Centers (CPACs), which together we understand will implement a regionally based industry model end-to-end revenue system, will fully address the concerns we and the individual veterans have raised in this testimony.

Mr. Chairman, we appreciate the Subcommittee's interest in this issue and we again thank you for the opportunity to present our views. We will appreciate your consideration of our views on this pressing and important matter to America's sick and disabled veterans. I would be pleased to address your questions, or those of other Subcommittee Members.

Statement of Denise A. Williams, Assistant Director for Health Policy, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to offer our views on this very important issue.

Background

In 1986 Public Law (P.L.) 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985, gave the Department of Veterans Affairs (VA) authority to bill health insurance companies for health care provided to non-service-connected veterans who have private health insurance. This legislation also authorized VA to collect co-payments from non-service-connected veterans based on their income. Veterans that are service-connected at a 50 percent or higher rating are eligible for cost free care and medication for their service-connected treatment.

As an expansion to that authority, in 1990 P.L. 101–508 established the Medical Care Cost Recovery (MCCR) revolving fund. This gave VA authority to seek reimbursement from third-party payers for the cost of medical care provided to insured service-connected veterans treated for NSC conditions. The law also authorized the per diem copayment and medication copayment programs. In 1997, P.L. 105–33 established VA's current Medical Care Collections Fund (MCCF) and authorized VA to retain collections from health insurers and veterans' copayments at the local medical center/Veterans Integrated Service Network (VISN) level.

In 2006, VA implemented a pilot project which created their Consolidated Patient Account Center. This was to address all operational areas contributing to the establishment and management of patient accounts and related billing and collections processes.

The American Legion has a long history of advocating on behalf of veterans. A very notable instance where this was evident was in March 2009, when Past National Commander David Rehbein met with President Obama and learned that the Administration planned to move forward on a proposal to charge veterans with private insurance for the treatment of service-connected injuries and illnesses at VA medical facilities. Under the proposed changes, VA would bill the veterans' private insurance company for treatment of their service-connected disabilities.

After fierce opposition from The American Legion and other Veterans' Service Organizations (VSOs), the Administration dropped their plan to bill private insurance companies for treatment of service-connected medical conditions.

Discussion

In June 2004, the Government Accountability Office (GAO) released a report, "Internal Control Weaknesses Impair Third-Party Collections," which stated that VA had inadequate patient intake procedures, insufficient documentation by physicians, a shortage of qualified billing coders, and insufficient automation, all which diminished VA's Medical Care Collection Fund (MCCF) collections. GAO conducted a followup audit in 2008 and echoed similar findings that VA has ineffective controls over their medical center billings and collections which limit revenue from third-party insurance companies. The report also concluded that VA lacks policies, procedures and reporting mechanism for oversight of third-party billings and collections.

The Department of Veterans Affairs Office of Inspector General (VAOIG) conducted an evaluation of the MCCF first-party billings and collections practices in 2004. The report found that veterans were inappropriately billed because of inaccurate medical facility Veterans Health Information Systems and Technology Architecture (VistA). In 2007, VAOIG carried out another evaluation of 10 facilities and ascertained that there were missed billing opportunities at all 10 facilities due to insufficient documentation of resident supervision.

Additionally, there were cases where episodes of care were not billed due to coding staff's lack of experience and insurance companies denying payment because billing staff placed incorrect information in the system. In light of these findings, we recommend that VA implement continuing education of all coders and their super-

visors. The American Legion urges VAOIG and GAO to conduct followup evaluations on their latest reports to determine whether VA has complied with their recommendations.

Mr. Chairman, although VA has made great strides in rectifying the issues surrounding their billing and collections practices, it is apparent that there is still room for improvement. As recent as April 2009, The American Legion compiled a total of 10 documented cases where VA erroneously billed service-connected veterans' private insurances for their service-connected medical care.

In one case, a veteran passed away in the Tampa VA Medical Center November 27, 2008. He was 100 percent service-connected for several conditions, and was also a military retiree enrolled in TRICARE for Life. Under the provisions of VHA Handbook 1660.06, dated May 16, 2008, the veteran's medical care was billed to TRICARE for Life. According to the Handbook since the VA cannot bill Medicaid, TRICARE for Life becomes the first payee. The Tampa VA Medical Center billed TRICARE for $1,017,019.81 and TRICARE paid $304,092.58. Again, the veteran was 100 percent service-connected and the Medical Center did have the correct information at the time they billed TRICARE.

According to the Handbook, the veteran is responsible for any and all TRICARE co-payments; in this case, the veteran was billed by TRICARE for a number of co-payments up to his catastrophic gap of $3000.00. There is no difference between this and billing private medical insurance.

In a second case, an 80 percent service-connected veteran reported that his wife's private insurance has been billed repeatedly for his treatment of service-connected illness. The veteran inquired about it through the VA Primary Care Team and was told they will continue to be billed as long as they have private insurance. The veteran explained that he was being billed for service-connected disabilities; however, the inappropriate billing continues. The American Legion is deeply concerned about this critical situation and contends VA work jointly with us to investigate these and any other cases, as well as collect pertinent records from affected veterans and take the necessary corrective measures. Additionally, we recommend that VA create a means to alert coders of service-connected conditions in their system and increase efforts and focus on monitoring accounts receivable.

In May 2009 The American Legion National Executive Committee adopted a resolution, which calls for GAO and VAOIG to conduct individual investigations into the allegations VA is billing service-connected veterans for their cost-free health care. In addition, the resolution urges VA to implement a third-party reimbursement and diagnostic team comprised of an individual within each VISN to review compliance and ensure veterans will not continue to be billed for their service-connected medical conditions.

Finally, we would like to take this opportunity to express our thanks to Chairman Filner for the introduction of H.R. 3365, The Medicare VA Reimbursement Act of 2009. The American Legion strongly supports this bill and would like to encourage your colleagues to follow suit. On behalf of The American Legion, I appreciate the invitation to present our views on this very important topic. This concludes my testimony.

Statement of Kay L. Daly, Director, Financial Management and Assurance, U.S. Government Accountability Office

VA Health Care: Ineffective Medical Center Controls Resulted in Inappropriate Billing and Collection Practices

GAO Highlights

Why GAO Did This Study

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

What GAO Recommends

In its June 2008 report, GAO made seven recommendations to improve VA's third-party billing and collection processes, including actions to improve (1) third-party billings (2) followup on unpaid amounts, and (3) management oversight of bill-

ing and collections. VA concurred with all seven recommendations and noted steps it was taking to address them. GAO will follow up to determine whether, and if so, to what extent, VA has taken action to address our recommendations.

What GAO Found

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

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

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

Estimated Control Failures on Timely Followup on Unpaid Bills			
Required followup	**VA-wide centers**	**CPAC centers**	**Non-CPAC centers**
Initial	69%	36%	71%
Second	44%	23%	45%
Third	20%	22%	17%

Source: GAO analysis of VA data.

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

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

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our prior work on the Department of Veterans Affairs' (VA) controls over medical center billings and collections. The department provides health care to eligible veterans through a system of Veterans Health Administration (VHA) medical facilities that constitute one of the largest health

care systems in the world. VA is authorized [1] to provide certain medical services to veterans with non-service-related conditions and to recover some of the cost of providing these additional benefits through billing and collecting payments from veterans' private health insurers, commonly referred to as third-party insurers.[2] VA can also use these third-party health insurance collections to supplement its medical care appropriations. VA third-party billing and collection operations are carried out through a nationwide network of 153 medical centers, 801 outpatient clinics, and 135 nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. VA reported in its fiscal year 2008 performance and accountability report that about 5½ million people received treatment in VA health care facilities, and VA collections for health care services totaled nearly $2.4 billion.[3]

Since 2001 we have reported that continuing weaknesses in VA billing processes and controls have impaired VA's ability to maximize the collections received from third-party insurers.[4] Most recently, in June 2008 we reported[5] on VA's ineffective controls over medical center billings and collections. My testimony today summarizes the findings of our June 2008 report that are most relevant to the subject of today's hearing. Specifically, I will focus on our findings concerning (1) the effectiveness of VA medical center billing processes at selected locations, (2) VA controls for performing timely followup on outstanding third-party receivables, and (3) the adequacy of VA oversight of billing and collection processes.

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

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

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

Our 2008 report found significant internal control weaknesses and inadequate management oversight that limited VA's ability to maximize collections from third-party insurers. Our 18 case studies included 10 medical centers with reported low billing performance and the 8 medical centers under the CPAC management initiative for regionalized billing and collection activity that were expected to be high performers. Our case study analysis of unbilled patient services at 18 case study med-

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

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

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

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

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

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

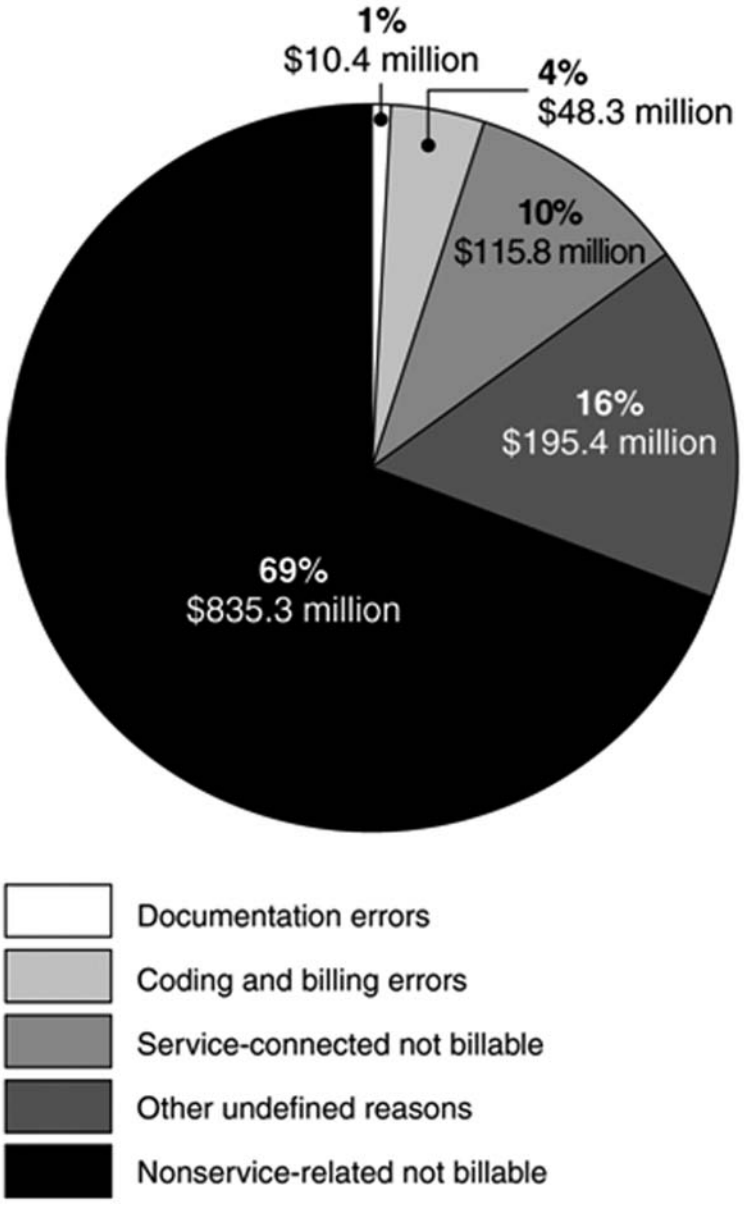
ical centers found excessive average days to bill, coding and billing errors, and a lack of management oversight, which raised questions about why $1.7 billion was not billed to third-party insurers at the 18 locations we reviewed. It is important that coding for medical services is accurate and timely because insurers will not accept improperly coded bills. Moreover, many insurers have national or regional contracts with VA that bar insurer liability for payment of bills received after a specified period of time after the date that medical services were provided, usually 1 year, but sometimes as little as 6 months.

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

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

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

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

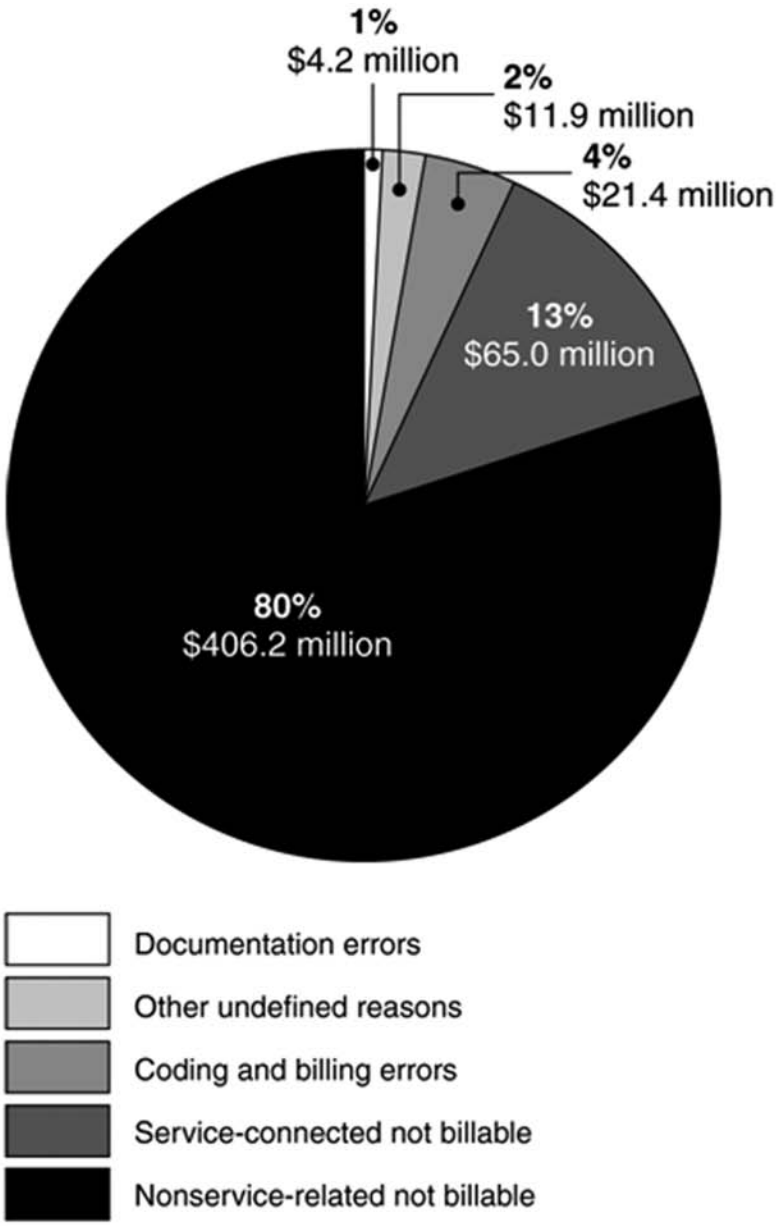


Source: GAO analysis of 10 case study medical centers' Reasons Not Billable data.

Our case study analysis of the eight medical centers under the CPAC initiative, with $508.7 million in unbilled amounts, found that CPAC officials performed a more thorough review of the billing function. Our analysis of fiscal year 2007 unbilled amounts for the eight CPAC centers showed that these centers' average days to bill ranged from 39 days to 68 days, compared to VA's 2007 goal of 60 days. As illustrated in figure 2, CPAC centers' documentation errors ($4.2 million), coding

and billing errors ($21.4 million), and other undefined reasons ($11.9 million) accounted for $37.5 million or about 7 percent of medical services costs that were not billed to third-party insurers.

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



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

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

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

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

Table 1: Estimated Failure Rates for Controls on Timely Followup on Unpaid Third Party Insurer Receivables

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

Source: GAO analysis of VA data.

Notes: Tests are of a VA-wide random-probability sample of third-party accounts-receivable data.

Failure rates are based on the lower bound of our two-sided, 95 percent confidence interval. Our sample included bills over $250.

The failure to make timely followup contacts and delays in initiating contacts with third-party insurance companies on unpaid amounts increase the risk that payments will not be collected, or that payments will be substantially delayed. Of the population of fiscal year 2007 billings that were used for our stratified random sample, VA had collected about 47 percent as of September 25, 2007.[10] Our analysis of accounts receivable aging data showed that 6.25 percent of the receivables balance as of the end of fiscal year 2007 was over 1 year old.[11]

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

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

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

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

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

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

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

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

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

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

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

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

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

Contact and Acknowledgments

For further information about this testimony, please contact Kay L. Daly, Director, Financial Management and Assurance at (202) 512–9095, or dalykl@gao.gov. Contact points for our offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Major contributors to this testimony included Gayle L. Fischer, Assistant Director; Carla J. Lewis, Assistant Director; F. Abe Dymond, Assistant General Counsel; Carl S. Barden; Deyanna J. Beeler;

Francine DelVecchio; Lauren S. Fassler; Patrick T. Frey; Jason Kelly; Amanda K. Miller; Meg Mills; Matthew L. Wood; and Matthew P. Zaun.

Statement of Gary M. Baker, MA, Chief Business Officer, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Mr. Ranking Member: thank you for providing me this opportunity to discuss the Department of Veterans Affairs' (VA) billing practices. I am accompanied today by Ms. Stephanie Mardon, Deputy Chief Business Officer for Revenue Operations, and Ms. Kristin Cunningham, Director of Business Operations.

VA is required by law to charge copayments to certain Veterans who meet income requirements and receive care for non-service-connected treatment. VA must also bill health insurance carriers for services provided to Veterans treated for their non-service-connected conditions. My testimony today will focus on VA's response to concerns expressed by Veterans and oversight bodies regarding VA's billing practices and the mechanisms VA has put in place to ensure charges are appropriate.

VA's Billing Guidelines

Veterans in Priority Group 1 (service connected 50 percent or more) are never charged a copayment. For other Veterans, VA currently has four types of non-service-connected copayments for which may be charged: outpatient, inpatient, extended care services and medication. Veterans are not charged copayments for a number of outpatient services including: publicly announced VA health fairs; screenings and immunizations; smoking and weight loss counseling; telephone care and laboratory; flat film radiology; and electrocardiograms. For primary care outpatient visits there is a $15 copayment charge and for specialty care outpatient visits a $50 copayment. Veterans do not receive more than one outpatient copayment charge per day.

For Veterans required to pay an inpatient copayment charge, rates vary based upon whether the Veteran is enrolled in Priority Group 7 or not. Veterans enrolled in Priority Group 8 and certain other Veterans are responsible for VA's full inpatient copayment and Veterans enrolled in Priority Group 7 and certain other Veterans are responsible for paying 20 percent of VA's inpatient copayment. Veterans in Priority Groups 1, 2 3 and 5 do not have to pay inpatient or outpatient copays. Veterans in Priority Groups 4 and 6 may be exempt due to income or special eligibility for treatment of certain conditions.

For Veterans required to pay extended care service copayments these are based on three levels of non-service-connected care including: inpatient, non-institutional and adult day health care. Actual copayments vary depending on the Veteran's financial situation.

For medication copayments, Veterans are not billed if they have a service-connected disability rated 50 percent or greater, they are former Prisoners of War, or if their medications are related to certain eligibility exceptions. Veterans enrolled in Priority Groups 2 thru 6 have a $960 calendar year cap on the amount that they can be charged for these copayments.

Veterans who are unable to pay VA's copayment charges are encouraged to complete requests for assistance including waivers, hardships, compromises and repayment plans. VA embarked on a program earlier this year to improve communication of these options to Veterans and their families through developing posters and other materials for local facilities and VA's Web site (see Appendices A through E). VA staff members are encouraged to ensure that Veterans and their families are aware of these options. In addition, Veterans and their families can call VA's First Party Call Center at the Health Resource Center in Topeka, KS using a toll-free number for assistance in understanding their copayment charges and payment alternative options.

VA bills private health insurers for medical care, supplies and prescriptions provided to Veterans for their non-service-connected conditions. VA cannot bill Medicare, but it can bill Medicare supplemental health insurance carriers for covered services. (*Reference 38 USC § 1729.)* Veterans are not responsible for paying any remaining balance of VA's insurance claim not paid or covered by their health insurance. Any payment received by VA is used to offset "dollar for dollar" a Veteran's VA copayment responsibility.

Ensuring Billing Accuracy

In VA's billing program, Veterans and their health insurers are not to be charged for care provided for their service-connected conditions. VA has a number of mechanisms that have been put in place to ensure Veterans and their third party health

insurers are charged appropriately. VA's health information system identifies Veterans who are service-connected, flags their record, and lists all rated service-connected disabilities. During each treatment encounter, the VA provider determines whether the medical care or prescriptions provided are related to the Veteran's rated service-connected conditions. This determination prevents bills from being generated automatically. In addition, when VA is notified that a Veteran is rated as service-connected retroactively, VA reviews the Veteran's account to ensure any bills that have may been generated for the newly rated conditions are cancelled or that refunds are generated back to the effective date of the service-connected decision. As an example, the 2008 National Defense Authorization Act exempted combat Veterans who were discharged from active duty on or after January 2003, from copayments for conditions possibly related to their combat service for a 5-year period. VA is now generating refunds for any copayments Veterans may have been required to make when their copayment exemption expired after 2 years under the previous authority. VA hopes this will assist those Veterans who served in the combat theater of operations.

The Veterans Service Organizations 2010 Independent Budget made recommendations to help VA improve billing practices: VA has already addressed many of these. In response to the recommendation regarding improved data exchange between the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA), VHA has made significant progress through enhancements to VHA's Veterans Health Information Systems Technology Architecture (VistA). This now contains information that provides medical staff data for more than 150 service-connected conditions. Additionally, medical center staff has access to other applications that provide more detailed information on rated disabilities. VHA staff has been participating in a pilot of the Virtual VA application which provides Web-based access to view rating decisions. This provides more detailed information concerning Veterans' service-connected disabilities. The pilot has proven very successful in providing clear, reliable information for use in service-connected determinations.

In response to the VSO recommendations that VA review our billing procedures and intensify training, VA has already put in place extensive training for clinical, coding and billing staff to appropriately determine service-connection and other special authority relationships for billing purposes. All providers receive a pocket card that outlines protocols for determining service-connected care for billing purposes. Business compliance staff at each level of VHA also perform a variety of first and third party billing compliance reviews that are routinely reported to VHA leadership.

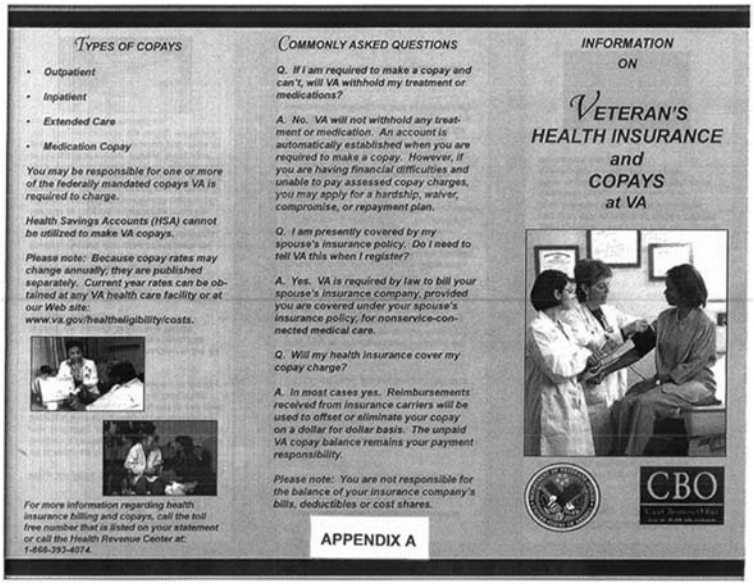
Over the last 5 years, VA has also developed many other initiatives to improve billing practices in response to VA Office of Inspector General (OIG) Report No. 03–00940–38, "Evaluation of Selected Medical Care Collection Fund First Party Billings and Collections" published on December 1, 2004. In this report, OIG identified that Priority Groups 1 and 5 Veterans were receiving compensation and pension benefits and their debts were being referred inappropriately to VA's Debt Management Center (DMC). In response to this report, VA published VHA Handbook 1030.03, "First Party Co-payment Monitoring Policy" (dated October 16, 2006) which established policies and procedures for monitoring possible inappropriate referral of debts to DMC. This handbook requires staff to conduct a full account review for any copayments charged to these Veterans to determine billing accuracy. Additionally, VA installed software in all VistA systems in August 2008 to ensure that these debts are not referred automatically for offset. This has resulted in dramatic reductions reducing inappropriate referrals from 89 percent at the time of the OIG report to 16 percent in Fiscal Year 2009.

VA also put in place several enhancements to strengthen its billing program in response to the July 2008 Government Accountability Office (GAO) Report 08–675, "Ineffective Controls over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies." To increase oversight and monitoring of the billing program, VA now requires staff to perform monthly reviews and report results to local compliances officers. In order to accurately classify care as not billable, VA implemented a software enhancement in July 2009 and provided training to staff. VA also implemented a mechanism to monitor and periodically audit these determinations. Finally, VA strengthened controls over accounts receivable by implementing monitors by VISN financial quality assurance staff.

Conclusion

Mr. Chairman, we appreciate the opportunity to respond to the concerns about VHA billing practices raised by Veterans and oversight bodies and to describe our efforts to improve the process. VA prides itself on ensuring that Veterans and their health insurers are appropriately charged for non-service-connected care. We are

equally committed to ensuring that Veterans are not billed inappropriately for treatment of service-connected conditions. To that end, VHA has instituted billing protocols, training, monitoring, and oversight systems. Should a Veteran receive a bill that appears to be in error, VA encourages Veterans to contact their local medical center revenue staff, who will review the bill with the Veteran and help to reconcile the issue. Thank you, again, for this opportunity. My colleagues and I are available for your questions.



TYPES OF COPAYS

- Outpatient
- Inpatient
- Extended Care
- Medication Copay

You may be responsible for one or more of the federally mandated copays VA is required to charge.

Health Savings Accounts (HSA) cannot be utilized to make VA copays.

Please note: Because copay rates may change annually, they are published separately. Current year rates can be obtained at any VA health care facility or at our Web site: www.va.gov/healtheligibility/costs.

For more information regarding health insurance billing and copays, call the toll free number that is listed on your statement or call the Health Revenue Center at: 1-866-393-4074.

COMMONLY ASKED QUESTIONS

Q. If I am required to make a copay and can't, will VA withhold my treatment or medications?

A. No. VA will not withhold any treatment or medication. An account is automatically established when you are required to make a copay. However, if you are having financial difficulties and unable to pay assessed copay charges, you may apply for a hardship, waiver, compromise, or repayment plan.

Q. I am presently covered by my spouse's insurance policy. Do I need to tell VA this when I register?

A. Yes. VA is required by law to bill your spouse's insurance company, provided you are covered under your spouse's insurance policy, for nonservice-connected medical care.

Q. Will my health insurance cover my copay charge?

A. In most cases yes. Reimbursements received from insurance carriers will be used to offset or eliminate your copay on a dollar for dollar basis. The unpaid VA copay balance remains your payment responsibility.

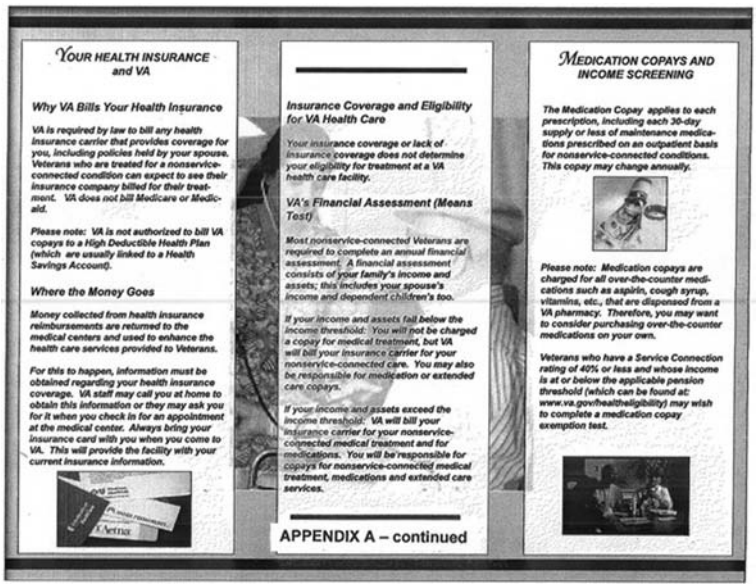
Please note: You are not responsible for the balance of your insurance company's bills, deductibles or cost shares.

APPENDIX A

INFORMATION ON

VETERAN'S HEALTH INSURANCE and COPAYS at VA

CBO



YOUR HEALTH INSURANCE and VA

Why VA Bills Your Health Insurance

VA is required by law to bill any health insurance carrier that provides coverage for you, including policies held by your spouse. Veterans who are treated for a nonservice-connected condition can expect to see their insurance company billed for their treatment. VA does not bill Medicare or Medicaid.

Please note: VA is not authorized to bill VA copays to a High Deductible Health Plan (which are usually linked to a Health Savings Account).

Where the Money Goes

Money collected from health insurance reimbursements are returned to the medical centers and used to enhance the health care services provided to Veterans.

For this to happen, information must be obtained regarding your health insurance coverage. VA staff may call you at home to obtain this information or they may ask you for it when you check in for an appointment at the medical center. Always bring your insurance card with you when you come to VA. This will provide the facility with your current insurance information.

Insurance Coverage and Eligibility for VA Health Care

Your insurance coverage or lack of insurance coverage does not determine your eligibility for treatment at a VA health care facility.

VA's Financial Assessment (Means Test)

Most nonservice-connected Veterans are required to complete an annual financial assessment. A financial assessment consists of your family's income and assets; this includes your spouse's income and dependent children's too.

If your income and assets fall below the income threshold: You will not be charged a copay for medical treatment, but VA will bill your insurance carrier for your nonservice-connected care. You may also be responsible for medication or extended care copays.

If your income and assets exceed the income threshold: VA will bill your insurance carrier for your nonservice-connected medical treatment and for medications. You will be responsible for copays for nonservice-connected medical treatment, medications and extended care services.

APPENDIX A – continued

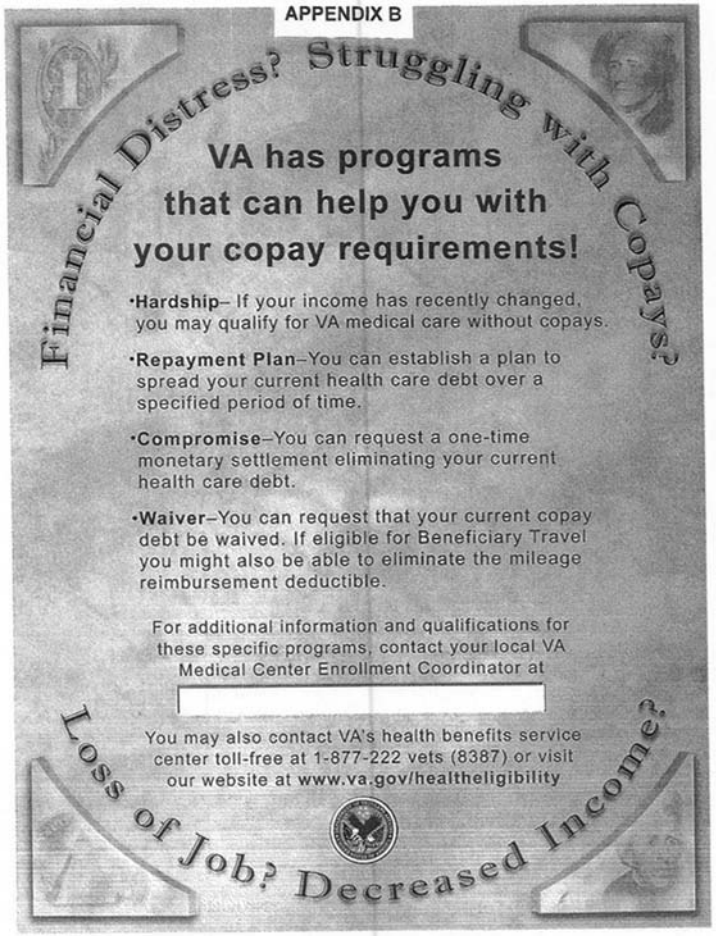
MEDICATION COPAYS AND INCOME SCREENING

The Medication Copay applies to each prescription, including each 30-day supply or less of maintenance medications prescribed on an outpatient basis for nonservice-connected conditions. This copay may change annually.

Please note: Medication copays are charged for all over-the-counter medications such as aspirin, cough syrup, vitamins, etc., that are dispensed from a VA pharmacy. Therefore, you may want to consider purchasing over-the-counter medications on your own.

Veterans who have a Service Connection rating of 40% or less and whose income is at or below the applicable pension threshold (which can be found at: www.va.gov/healtheligibility) may wish to complete a medication copay exemption test.

APPENDIX B


Financial Distress? Struggling with Copays?
VA has programs that can help you with your copay requirements!
•Hardship– If your income has recently changed, you may qualify for VA medical care without copays.
•Repayment Plan–You can establish a plan to spread your current health care debt over a specified period of time.
•Compromise–You can request a one-time monetary settlement eliminating your current health care debt.
•Waiver–You can request that your current copay debt be waived. If eligible for Beneficiary Travel you might also be able to eliminate the mileage reimbursement deductible.
For additional information and qualifications for these specific programs, contact your local VA Medical Center Enrollment Coordinator at
You may also contact VA's health benefits service center toll-free at 1-877-222 vets (8387) or visit our website at www.va.gov/healtheligibility
Loss of Job? Decreased Income?

APPENDIX C

Financial Hardship? In-Between Jobs?

VA's Medical Care Hardship program may help you qualify for VA Health Care enrollment!

If your income has recently changed, you may qualify for enrollment even if it was denied previously based on your household income. Or, perhaps you have put off applying for enrollment because you think your income is too high. Now may be the time to provide updated financial information or apply for enrollment.

Personal circumstances such as loss of employment, sudden decrease in income, or increases in out-of-pocket family health care expenses factor into VA's hardship determination.

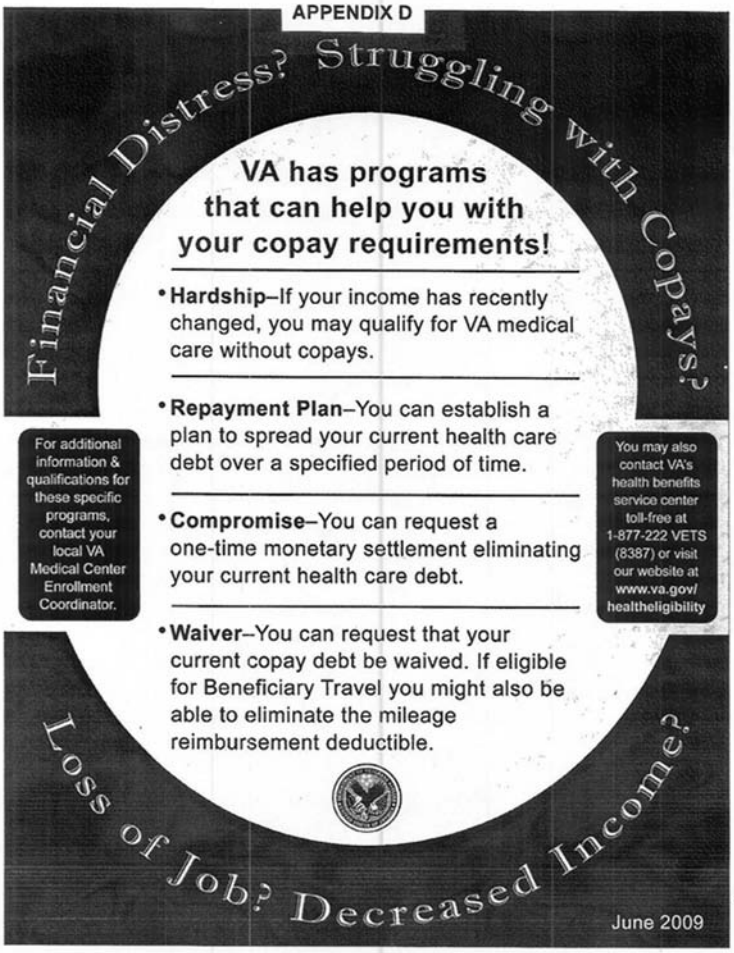
If your current and projected financial situation puts you below the VA Means Test Threshold or Geographic Means Test Threshold for your area, you may qualify for enrollment and cost-free VA medical care.

For additional information and qualifications for this program, contact your local VA Medical Center Enrollment Coordinator at

You may also contact VA's health benefits service center toll-free at 1-877-222 VETS (8387) or visit our website at **www.va.gov/healtheligibility**

Let Us Help—Contact Us Today

APPENDIX D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You may also contact VA's health benefits service center toll-free at 1-877-222 VETS (8387) or visit our website at www.va.gov/healtheligibility
Loss of Job? Decreased Income?
June 2009

APPENDIX E

VA HEALTH CARE

Fact Sheet 164-10
June 2009

VA National Income Thresholds

Financial Test Year 2009

Veteran with	Free VA Prescriptions and travel benefits (maximum allowable rate):	Free VA Health Care: (0% service connected {noncompensable} and nonservice-connected veterans only):	Medical expenses deduction (5% of maximum allowable pension rate from previous year):
0 dependents	$11,830 or less	$29,402 or less	$559
1 dependent	$15,493 or less	$35,284 or less	$732
2 dependents	$17,513 or less	$37,304 or less	$828
3 dependents	$19,533 or less	$39,324 or less	$923
4 dependents	$21,553 or less	$41,344 or less	$1,019
For each additional dependent add:	$2,020	$2,020	5% of maximum allowable pension rate
Medicare Deductible: $1,068		Income & Asset Net Worth: $80,000	

Financial Test Year 2008

Veteran with	Free VA Prescriptions and travel benefits (maximum allowable rate):	Free VA Health Care: (0% service connected {noncompensable} and nonservice-connected veterans only):	Medical expenses deduction (5% of maximum allowable pension rate from previous year):
0 dependents	$11,181 or less	$28,429 or less	$546
1 dependent	$14,643 or less	$34,117 or less	$716
2 dependents	$16,552 or less	$36,026 or less	$809
3 dependents	$18,461 or less	$37,935 or less	$902
4 dependents	$20,370 or less	$39,844 or less	$996
For each additional dependent add:	$1,909	$1,909	5% of maximum allowable pension rate
Medicare Deductible: $1,024		Income & Asset Net Worth: $80,000	

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
October 20, 2009

Ms. Kay Daly
Director
Financial Management and Assurance
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Daly:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Identifying the Causes of Inappropriate Billing Practices by the VA" that took place on October 15, 2009.

Please provide answers to the following questions by December 2, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Although the June 2008 GAO report focused on under-billing, is it possible to infer that the VA may have issues with over-billing because the VA has internal control weaknesses and problems with omissions in documentation and use of inaccurate clinical service codes?
2. There are valid reasons that VA does not bill third-parties for medical care, such as medical care provided for service-connected conditions and when services are covered by Medicare. Is VA ensuring that patient medical services provided that are placed into non-billable categories are correctly placed there?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by December 2, 2009.

Sincerely,

Michael H. Michaud
Chairman

U.S. Government Accountability Office
Washington, DC.
November 23, 2009

The Honorable Michael H. Michaud
Chairman
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

Subject: The Department of Veterans Affairs (VA) Health Care: Response to Hearing Questions Related to Controls over VA's Medical Center Billings and Collections

Dear Mr. Chairman:

On October 15, 2009, we testified before your Subcommittee at a hearing entitled, *Inappropriate Billing Practices of the VA: Identifying the Causes and Exploring Potential Solutions.*[1] Our testimony was primarily based on our June 2008 report[2] on (1) the effectiveness of VA medical center billing processes at selected locations, (2) VA controls for performing timely followup on outstanding third-party receivables, and (3) the adequacy of VA oversight of billing and collection processes.

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[1] GAO, *VA Health Care: Ineffective Medical Center Controls Resulted in Inappropriate Billing and Collection Practices,* GAO–10–152T (Washington, D.C.: Oct. 15, 2009).

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

This letter responds to your October 20, 2009, request to provide answers to followup questions relating to our October 15, 2009, testimony. Your questions, along with our responses, based primarily on our June 2008 report, follow.

1. Although the June 2008 GAO report focused on under-billing, is it possible to infer that the VA may have issues with over-billing because the VA has internal control weaknesses and problems with omissions in documentation and use of inaccurate clinical service codes?

As we testified before your Subcommittee in October 2009,[3] while our June 2008 report focused on VA underbillings and related control weaknesses, the weaknesses we identified could also result in VA overbillings to third-party insurers or veterans. For example, weak controls permitting billing errors could result in overbilling for services to veterans for service-connected illnesses or conditions. Until VA addresses its significant, continuing weaknesses in controls over coding, billing, and collections followup, it will continue to be at risk of millions of dollars in erroneous billings, including both over- and underbilling for veterans' medical-connected services. These errors can negatively affect VA's ability to provide medical care to the Nation's veterans.

2. There are valid reasons that VA does not bill third-parties for medical care, such as medical care provided for service-connected conditions and when services are covered by Medicare. Is VA ensuring that patient medical services provided that are placed into non-billable categories are correctly placed there?

Our case study analysis of unbilled patient services at 18 VA medical centers found, among other things, that coding and billing errors as well as a lack of management oversight raised questions about whether $1.7 billion was correctly not billed to third-party insurers. While $1.4 billion of this amount appeared to relate to services for which VA does not have a cost recovery right, such as medical care for service-connected conditions and services covered by Medicare and was therefore nonbillable,[4] we found that medical center management did not always validate the cited reasons these amounts were unbilled. For example, managers at 10 case study medical centers did not perform adequate reviews of cited treatment classifications to ensure billings were appropriately nonbillable.

VA advised us in November 2009 it has taken the following steps to help ensure that patient medical services provided are correctly placed into the nonbillable categories.

- In December 2008, VA issued a fact sheet that detailed new procedures for monitoring "reasons not billable" codes for accuracy and timeliness.
- In February 2009, VA issued Veterans Health Administration Directive 2009–010, *Monitoring "Reasons Not Billable"* to formalize the monitoring process for coding and billing accuracy related to nonbillable encounters.
- In July 2009, VA deployed a software enhancement to its Veterans Health Information Systems and Technology Architecture (VistA) system[5] to standardize the "reasons not billable" codes used to track why a specific medical treatment is not billable.
- In July and August 2009, VA provided national training to staff on the system enhancement.

Although we have not independently assessed the adequacy of these actions, if fully and effectively implemented, they appear to have merit in better ensuring VA patients' medical care service billings are correctly classified as nonbillable.

If you or your staff have questions about the responses to the questions, please contact me at (202) 512–9095 or by e-mail at dalykl@gao.gov. A key contributor to this correspondence was Carla Lewis, Assistant Director.

Sincerely yours,

Kay L. Daly
Director
Financial Management and Assurance

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[3] GAO–10–152T.

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

[5] VistA is a comprehensive medical records system. VistA includes an accounts receivable module that supports third-party billings and collections.

Committee on Veterans' Affairs
Washington, DC.
October 20, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20240

Dear Secretary Shinseki:

Thank you for the testimony of Gary M. Baker, Chief Business Officer for the Veterans Health Administration, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Identifying the Causes of Inappropriate Billing Practices by the VA" that took place on October 15, 2009.

Please provide answers to the following questions by December 2, 2009, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Does the VA collect data to assess the prevalence of their inappropriate billing practices? Is this linked to a performance measure to track VA's progress in decreasing the number of inappropriate billings?
2. How does the VA minimize improper billing? For example, are there directives or requirements for standardized procedures to limit coding errors and to address other issues leading to erroneous billing?
3. The witnesses speaking on behalf of veterans service organizations testified that non-service connected veterans may be billed multiple times for a single episode of treatment. What do you think are some potential reasons for this error? Is it a human processing error and/or an IT coding error?
4. What is the VA doing to improve the communication between VHA and VBA so that information about service-connected conditions is complete and timely?
5. In their testimony, the Paralyzed Veterans of America cited a case where the VA bills veterans who are rated with 100 percent total and permanent disability. Why is the VA billing these individuals? Is this practice allowed in statute or regulations, or do these cases reflect unintended billings?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by December 2, 2009.

Sincerely,

Michael H. Michaud
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman
House Committee on Veterans' Affairs
Subcommittee on Health
Identifying the Causes of Inappropriate Billing Practices by the VA
October 15, 2009

Question 1: Does the VA collect data to assess the prevalence of their inappropriate billing practices? Is this linked to a performance measure to track VA's progress in decreasing the number of inappropriate billings?

Response: Data on bills created in error is currently collected on a local basis at each facility. However, VA is currently developing procedures to collect this data at a national level, so that trends can be analyzed to better drive system-wide improvements in billing practices.

The VHA's Office of Compliance and Business Integrity (CBI), which oversees VHA's revenue operations, implemented a series of metrics that monitor high risk activities impacting the revenue cycle, to include billings. CBI continuously reviews revenue cycle activities and identifies areas of high risk that may need a focused review.

Question 2: How does the VA minimize improper billing? For example, are there directives or requirements for standardized procedures to limit coding errors to address other issues leading to erroneous billing?

Response: VHA has implemented a number of standardized procedures and training initiatives in order to minimize bills created in error. In November 2007, VHA published Handbook 1907.03, Health Information Management Clinical Coding Program Procedures, to establish minimum bill coding accuracy standards and provide procedures for conducting coding reviews for many different purposes, including third-party billing. In December 2008, VHA developed and issued to the field, new procedures specifically for monitoring reasons not billable codes for accuracy and timeliness. This process was formalized via a directive (VHA 2009–010). VHA also implemented a system enhancement along with training modules to standardize "reasons not billable" codes, which allows for better oversight of this process.

VHA has implemented a number of training programs on specific billing topics including billing associated with Combat Veteran special authority to ensure staff understands the authorities and billing requirements for these topics. VHA also presented a training program to field staff on Service/Non-service-Connected care and Special Treatment Authorities in September 2009. VHA has focused targeted training efforts tailored to clinicians through issuance in August 2009, of Physician Documentation FlipCards, which provide quick reference resources including tips on documentation, evaluation and management coding, medication copayments, and service-connected/special treatment authorities.

Finally, VHA has used hybrid title 38 hiring authority to increase the number of qualified coders and provided opportunities for special advancement for professional achievement while in VA service. A national Health Information Management (HIM) inventory conducted in October 2008, reported 1,282 coders at VA facilities which represent an increase of 394 coders since 2007. Eighty-two percent (1,048) of coders hold HIM credentials, an increase of 255 coders since 2007. In order to assure this staff receives ongoing training, educational programs are provided both via satellite and web-based modalities. Also, a tool kit containing coding and documentation improvement strategies is posted on the HIM Web site along with a Metrics Dashboard which includes coding indicators.

Question 3: The witnesses speaking on behalf of Veterans Service Organizations (VSOs) testified that non-service connected Veterans may be billed multiple times for a single episode of treatment. What do you think are some potential reasons for this error? Is it a human processing error and/or an IT coding?

Response: It is important to note that Veterans receive a separate prescription copayment charge for each individual prescription that may have been issued during a single treatment episode. These individual prescription copayment billings for non-service connected prescriptions may be interpreted as multiple billings for the same episode of care by the Veteran. VA's billing system is designed to provide monthly statements so the Veteran has an opportunity to either pay the charges or request administrative relief through waiver or compromise. If the charges are not paid after three statements are issued, and no new charges have been incurred, no further statements are issued for those charges. If the Veteran incurs additional charges after the initial charges are reported on a statement, the balance of unpaid charges will continue to be shown on each subsequent statement. VHA believes that the billing system is working as designed but more education is needed on the patient statements for Veterans.

Question 4: What is VA doing to improve the communications between VHA and VBA so that information about service-connected conditions is complete and timely?

Response: VA has made significant progress in the exchange of data between VBA and VHA. The information contained in the VistA system for medical staff now allows for more than 150 service connected conditions. As VBA has transitioned to its VETSNET application, VHA has gained access to more detailed listings of service-connected conditions without the limitation to six service-connected conditions, as had been the case with the Benefits Delivery Network system. In addition, medical center staff has access to other applications which provide more detailed information on rated disabilities such as the web-based Hospital INQuiry(HINQ) application. VHA staff has been participating in a pilot of the Virtual VA application which provides web-based access to view rating decisions. This provides more detailed information concerning Veterans' service-connected disabilities. This pilot has proven to be very successful in providing clear and reliable information for use in service-connection determinations. The pilot is expected to be expanded to more staff when technical infrastructure capability is expanded.

Question 5: In their testimony, the Paralyzed Veterans of America cited a case where the VA bills Veterans who are rated with 100 percent total and permanent disability. Why is the VA billing these individuals? Is this practice allowed in statute or regulations, or do these cases reflect unintended billings?

Response: Veterans rated 100 percent total and permanent should not receive copayment bills for any services. However, by statute, their third party insurance may be billed for care provided for conditions not adjudicated as service-connected by VBA. VA clinical staff is required to identify such non-service-connected care for billing to third party insurers. Also, if a Veteran had a lesser percentage disability and was recently determined to be 100 percent total and permanent, he/she may still receive bills from treatment provided at the lower rated disability or for non-service connected disabilities while rated less than 100 percent. Although VA strives for zero errors in our billing practices, we know there are situations where Veterans or third party insurers may have received bills in error. If this situation occurs, Veterans are encouraged to contact their local medical center revenue staff who will review the bill and cancel it as appropriate.