

Prepared by:

Grant Thornton LLP

**A Product of the CMS Alliance to Modernize Health Care
Federally Funded Research and Development Center
Centers for Medicare & Medicaid Services (CMS)**

Prepared For:

U.S. Department of Veterans Affairs

At the Request of:

Veterans Access, Choice and Accountability Act of 2014
Section 201: Independent Assessment of the Health Care Delivery
Systems and Management Processes of the Department of Veterans
Affairs

Assessment I (Business Processes)

September 1, 2015

Prepared for CAMH under:

Prime Contract No. HHS-M500-2012-00008I

Prime Task Order No. VA118A14F0373

This document was prepared for authorized distribution only. It has not been approved for public release.

©2015 Grant Thornton. All rights reserved.

This page intentionally left blank.

Preface

Congress enacted and President Obama signed into law the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146) (“Veterans Choice Act”), as amended by the Department of Veterans Affairs (VA) Expiring Authorities Act of 2014 (Public Law 113-175), to improve access to timely, high-quality health care for Veterans. Under “Title II – Health Care Administrative Matters,” Section 201 calls for an Independent Assessment of 12 areas of VA’s health care delivery systems and management processes.

VA engaged the Institute of Medicine of the National Academies to prepare an assessment of access standards and engaged the Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Healthcare (CAMH)¹ to serve as the program integrator and as primary developer of the remaining 11 Veterans Choice Act independent assessments. CAMH subcontracted with Grant Thornton, McKinsey & Company, and the RAND Corporation to conduct 10 independent assessments as specified in Section 201, with MITRE conducting the 11th assessment. Drawing on the results of the 12 assessments, CAMH also produced the Integrated Report in this volume, which contains key findings and recommendations. CAMH is furnishing the complete set of reports to the Secretary of Veterans Affairs, the Committee on Veterans’ Affairs of the Senate, the Committee on Veterans’ Affairs of the House of Representatives, and the Commission on Care.

The research addressed in this report was conducted by Grant Thornton LLP, under a subcontract with The MITRE Corporation. Grant Thornton also subcontracted with Navigant Consulting to support the assessment.

¹ The CMS Alliance to Modernize Healthcare (CAMH), sponsored by the Centers for Medicare & Medicaid Services (CMS), is a federally funded research and development center (FFRDC) operated by The MITRE Corporation, a not-for-profit company chartered to work in the public interest. For additional information, see the CMS Alliance to Modernize Healthcare (CAMH) website (<http://www.mitre.org/centers/cms-alliances-to-modernize-healthcare/who-we-are/the-camh-difference>).

This page intentionally left blank.

Executive Summary

Introduction

Assessment I of Section 201, Title II – Health Care Administrative Matters of the Choice Act, or “Veterans Choice Act,” requires an independent assessment of the business processes of the Veterans Health Administration (VHA). Business processes refer to the revenue for direct “**VA Care**” (herein referred to as “VHA Revenue”) and payment for private-sector “**Non-VA Care**” services. Per the legislation, this includes processes relating to furnishing non-department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including mechanisms to avoid penalties, increase collections, and increase accuracy and timeliness to external providers and vendors. The business processes used to manage these functions are critical because they affect access, quality of care, and the overall patient experience for our Veterans and their families.

As the largest health care delivery system in the United States, VHA provides and pays for Veteran medical care. The cost of health care, similar to industry, continues to rise. The number of Veterans receiving care from VA has almost doubled since 1997.² In fiscal year (FY) 2014, VHA had over \$156 billion in obligations and delivered direct VA Care to over 6.4 million unique Veterans. Direct VA Care alone cannot meet all Veterans’ health needs; therefore, VHA outsources and pays for external providers, essentially acting as an “insurer” for medically necessary Non-VA Care that is unavailable at VHA facilities (Non-VA Care, in this report). In 2014, Non-VA Care treated approximately 1.2 million unique Veterans with more than 14 million claims valued at \$5.5 billion (claims paid). This represents a 400 percent increase over the last ten years and, due to the Veterans Choice Act, the amount is expected to grow.

Financial health is critical for the long-term viability of the Veterans’ health care system. To help offset the growing cost of care funded through congressional appropriations, legislation gives VHA authority as a provider to seek reimbursement from insurance companies for non-service connected treatment. Likewise, VHA has authority to seek out-of-pocket patient expenses for non-service connected care. In 2014, VHA billed approximately \$6 billion for VA Care and collected almost \$3.2 billion from third-party reimbursements. In 2014, VHA billed approximately \$106 million and collected \$85 million from Veteran (first-party) co-payments.

VHA’s health care delivery system is unlike any other health system. VHA has a multitude of challenges driven by its unique combination of scale and scope, geographical dispersion, demographics served, funding model, regulation, benefit structure, and oversight. Nevertheless, the effective provision and payment of direct care and Non-VA Care services, and the business processes used to manage these functions, are critical because they affect access, quality of care, and the overall patient experience for Veterans and their families.

VHA business processes have evolved over the past several years to support VA’s mission through operational improvements. VHA has historically addressed business process challenges

²VERA Veterans Equitable Resource Allocation 2014, VA Under Secretary for Health, May 2104, Pg. 48.

through technology initiatives, changes in structure, and process standardization with many success stories on improving delivery of VA’s mission through business processes. While improvements have been realized in recent years, additional work remains. Reports from the VA Office of Inspector General (OIG) and the Government Accountability Office (GAO) have identified weaknesses in VA’s control and oversight of payments made to Non-VA entities, and have identified areas for improvement in revenue collection from third parties.

Methodology

The Assessment I team conducted interviews and discussions with executive leadership from the Chief Business Office (CBO)—which comprises both VHA Revenue Operations and Purchased Care, VHA Health Information Management Services (HIMS), and Patient Centered Community Care (PC3) vendors (Health Net Federal Services and TriWest). Additionally, we interviewed 107 VHA staff and conducted 30 process walkthroughs in the course of our site visits to the Health Administration Center (HAC), three Consolidated Patient Account Centers (CPACs), and eight VA Medical Centers (VAMCs). We analyzed 776 documents and datasets, including VHA policy documents; organization charts; financial reports; standard operating procedures; previous OIG, GAO, and internal VA Oversight reports; and other studies for insight into issues, best practices, and process improvements. Our data findings are based on available VHA data for the years 2012 to 2014. We analyzed and compared VHA performance against relevant industry benchmarks and high-performing practices to substantiate evidence-based conclusions and recommendations for improvements to VHA business financial management processes as outlined in the Choice Act. The following table lists the processes we assessed.

Table ES-1. Processes Assessed by Assessment I Team

<p><i>VA Care (addresses Section 201, I, ii, and iii):</i></p> <ul style="list-style-type: none"> ▪ Scheduling, Pre-registration, and Registration ▪ Clinical Documentation and Coding ▪ Patient Accounting 	<p><i>Non-VA Care (addresses Section 201, I, i, and iv):</i></p> <ul style="list-style-type: none"> ▪ Consults and Authorization for Care ▪ Claims Adjudication ▪ Payment Processing
--	---

This assessment was conducted during a period of significant change in organizational responsibility for Non-VA Care. Section 106 of the Veterans Choice Act “[transferred] the authority to pay for hospital care, medical services, and other health care furnished through non-Department of Veterans Affairs providers from the VISN and medical centers of the Department of Veterans Affairs, to the CBO of the Veterans Health Administration of the Department of Veterans Affairs.”³

The implementation resulted in the consolidation of claims processing staff, provided CBO with the authority to standardize processes and procedures to pay Non-VA claims, and enforce

³ Veterans Access, Choice, and Accountability Act of 2014

related rules and regulations across VAMCs nationally. The transfer of authority and responsibility to CBO occurred on October 1, 2015. As the timing of our assessment coincided with this transition, we encountered business processes that were in varying stages of consolidation, redesign, and standardization. We also note that due to timing, most of the data we collected and analyzed related to Non-VA Care was for claims paid before CBO accepted operational responsibility as provided by the Choice Act.

Summary of Findings

VHA Revenue—VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Cultural Barriers.

Ineffective Veteran-facing (front-end) VAMC processes for insurance identification, and clinical documentation, and outpatient coding issues result in CPAC staff members having to address issues “after-the-fact.” The issues correspond to \$581 million in denials from insurance companies in 2014.

For first-party (Veteran) co-payments, VAMC staff members are not collecting the co-payments at the point-of-service and CPACs must collect the co-payments weeks to months after the date of service. Further, based on feedback from VAMC leadership, Veterans do not always understand the need to provide insurance information and VHA staff can be reluctant to ask for it.

Revenue processes span across VAMCs and CPACs; however, only the CPACs are accountable for revenue collection and the associated performance outcomes. VAMC commitment is required to monitor and correct issues early in the process to reduce collections delays and denials.

Non-VA Care Payments—VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non-VA Care Claims Timely and Accurately.

VHA’s complex and disparate processes for paying Non-VA Care claims are confusing to Non-VA providers and VHA staff, resulting in inconsistencies in authorization and payment practices. VHA’s mechanisms to pay Non-VA claims timely and avoid delinquent payments, particularly at select VISNs. However, inadequate data analytics indicate the issues could be more widespread. VHA mechanisms to avoid delinquent payments to external providers are inadequate putting VHA at risk for significant interest penalties.⁴

Inadequate claims submission guidance discourages widespread use of electronic claims submission. VHA receives only a small percentage of non-VA claims electronically, which increases workload, manual processing, and the likelihood for payment errors. Low staff retention and a 20 percent vacancy rate further exacerbate delays and errors in claims payments.

⁴ There is an ongoing VA Office of General Counsel review of the universe of payments to which the Prompt Payment Act applies.

VHA established Patient Centered Community Care (PC3) to expand Non-VA care access by entering into national contracts with Healthnet and TriWest to provide Veteran health care on a fee for service basis. Feedback from VA employees interviewed indicate that PC3 is experiencing challenges due to gaps in the non-VA provider network.

Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.

VHA will not be able to make necessary improvements in their billing and collection processes without modern, automated technology. Antiquated systems used to support the revenue collection processes for third-party reimbursements and first-party (Veteran) co-payments do not provide needed functionality. These systems require significant manual intervention and processing that creates an environment prone to human error and delayed claims payments from insurers.

VHA software tools and functions do not interoperate across clinical and revenue management systems and their limited interoperability with other internal and external systems inhibits VHA's ability to bill and collect revenue accurately and rapidly.

Few Non-VA providers submit their claims to VHA electronically, relying instead on paper claims, which reduces payment timeliness and accuracy. In addition, staff members process claims manually compared to private-sector benchmarks of 79 percent automation.

Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.

VHA lacks standard national reporting of key performance metrics for timely insurance identification and verification across VHA, inhibiting visibility into VAMC insurance capture performance of VAMCs. In addition, VHA cannot establish effective productivity standards and monitor Non-VA Care staff performance because processes are inconsistent across VAMCs and VISNs. Current decision support capabilities are not sufficient to provide oversight and management of Non-VA Care claims processing and payment. Proactive and retrospective processes are in place to find inaccurate payments, but these practices are highly manual.

Summary of Recommendations

Below is a summary of high-level recommendations, accompanied by duration estimates for completion.

Recommendation 1—VHA: Develop a long-term comprehensive plan for provision of and payment for non-VA health care services (180 days).

The expansion of Non-VA Care over the last decade has resulted in a combination of programs that lack sufficient infrastructure to successfully perform the business functions today or meet the demands of the future. The demand for Non-VA Care will be determined, in large part, by the decisions made regarding VHA care and, in turn, by VHA's capacity to meet demand for services. For example, decisions about VHA facilities and workforce will affect demand for Non-

VA Care, as will changes in the demographics and clinical needs of Veterans. VHA should adjust the plan as necessary depending on ongoing studies regarding VHA's capacity.

Recommendation 2—VHA: Establish a formal governance model that allows CBO and VISN leadership to converge, aligning interests and accountability (90 days).

The growth of both VHA and Non-VA Care requires an increased focus on business processes to sustain care for an increasing Veteran population. An organizational structure that balances central management with local autonomy is vital to VHA. VHA must align accountability and interests at the leadership level of CBO and the VISNs. Under the current alignment, CBO is dependent upon the VAMCs and VISNs to execute core business functions. With CBO and VISNs reporting separately to the VHA Office of the Under Secretary, VAMC priorities do not always align with CBO's. Placing both organizations under a single governance structure will promote convergence of interests, accountability, cooperation, and coordination.

Recommendation 3—VHA: Standardize policies and procedures for execution of Non-VA Care, particularly the Choice Act, and communicate those policies and procedures to Veterans, VHA staff, VHA providers, and Non-VA providers (90 days).

Examination of the claims processing protocols and operations revealed opportunities to standardize the manner in which VHA implements Non-VA Care and the Veterans Choice Act across the organization. Standardization will enable VHA to communicate processes and benefits effectively to both patients and Non-VA providers.

Recommendation 4—VHA: Employ industry standard automated solutions to bill claims for VHA medical care (revenue) and pay claims for Non-VA Care (payment) to increase collections, to improve payment timeliness and accuracy (2 years).

The growth of both VHA and Non-VA Care over the last decade has produced a combination of programs that lack sufficient technology to support the execution of routine business functions. In large part, these deficiencies result in a high degree of manual intervention required to bill and pay claims. The focus on automation should expand to include integration with front-end processes such as scheduling, insurance identification and verification, medical records, and coding.

Recommendation 5—VHA: Consider and further evaluate aligning the Patient Intake and Health Information Management Service (to include Coding) functions under CBO (180 days).

An emerging practice in private-sector health care is to align all components of the revenue cycle under the Chief Financial Officer (CFO) linking job responsibilities to financial performance. VHA's revenue cycle activities currently owned by the VAMC/VISN are Scheduling, Pre-Registration, Registration and Coding—all primary functions for identifying and verifying insurance, and ensuring accurate and timely first- and third-party collections. The private sector has recognized that aligning these functions under a single organization improves accountability and revenue cycle performance. Our findings indicate that the separation between business process and organizational structure within the VHA revenue cycle processes has resulted in a lack of coordination and consistency in these functional areas. Given the size

and complexity of VHA compared to the private sector, any realignment needs to be carefully considered. Added to this, the VHA CBO recently completed a very large organizational consolidation of Non-VA Care employees and adding significantly more responsibility to the CBO at this time may be difficult for the CBO to absorb in the near-term.

Recommendation 6—VHA: Align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector (6 months).

VHA should continue its progress toward implementation and management reporting of common industry performance measures. Once these practices are in place, VHA should identify performance standards that balance meeting VHA requirements with achievable, incremental performance improvements. This approach would immediately allow VHA to leverage common industry measures and benchmarks to conduct analysis, make informed decisions, and help to bring VHA performance into congruence with private-sector benchmarks.

Recommendation 7—VHA: Simplify the rules, policies, and regulations governing revenue, Non-VA Care, eligibility, priority groups, and service connections, educate all stakeholders, and institute effective change management (2 years).

Simplifying the rules, policies, and regulations will allow VHA to execute business processes uniformly, and to communicate clearly with all stakeholders.

Recommendation 8—VHA: Identify, share and institutionalize best practices across the agency (6 months).

There are numerous examples of business practices in VHA (as described in section 4 of this report) that produce results that significantly exceed VHA averages. VHA should develop a recurring process to examine these peer organizations' "positive deviants" and determine where successful practices apply to VHA business processes. Doing so will enable VHA to not only standardize, but also improve upon current best practices.

Moving Forward

Our recommendations reflect our independent assessment of the effectiveness of ongoing operations, and opportunities to improve financial management of payments, reimbursements, and collections for VA and Non-VA Care. We believe these recommendations provide the next steps in building business operations that support VHA's overall health care delivery mission, and improve the relationship with business partners and Veterans alike.

Assessment I Report Organization

This report includes ten chapters and seven appendices.

Chapters 1 through 3 provide an introduction, an overview of our study methodology, and a summary of the VHA organizations that we examined during our assessment.

Chapter 4 identifies some of the best practices we encountered during our site visits and provides recommendations that can assist in spreading these best practices across VHA.

Chapter 5 summarizes the overarching findings, key sub-findings, and associated recommendations that are the core of our assessment report. This chapter also includes some additional considerations for the longer term.

Chapters 6 through 9 provides details of our analysis, including topical background information to enhance reader understanding, explicit references to the data-driven evidence, interview results, and findings and conclusions from our financial analyses. We also identify strategic and actionable, tactical-level recommendations and actions that VHA can take to improve their processes and outcomes.

- Chapter 6 covers VA Revenue—Billings and Collections.
- Chapter 7 covers Non-VA Care—Payments.
- Chapter 8 addresses Information Technology.
- Chapter 9 discusses Oversight and Metrics.
- Chapter 10 concludes the report.
- Appendices A through F provide additional details for further review and information.

This page intentionally left blank.

Table of Contents

1	Introduction	1
1.1	Scope.....	3
1.2	Assessment I Relationships to Other Assessments	3
1.3	Limitations.....	4
2	Methodology	5
2.1	Phase 1: Planning and Discovery	5
2.2	Phase 2: Site Visit and Data Analysis	6
2.3	Phase 3: Findings and Recommendations	8
3	Key Organizations and Stakeholders Examined.....	9
3.1	Chief Business Office (CBO)	10
3.1.1	CBO Revenue Operations.....	10
3.1.2	CBO Purchased Care (CBOPC).....	11
3.2	Veterans Integrated Service Networks (VISN).....	11
3.2.1	Department of Veterans Affairs Medical Center (VAMC)	12
4	Best Practices	13
4.1	Identified Best Practices	13
4.2	Recommendations for Expanding Best Practices	15
5	Overarching Findings and Recommendations	17
5.1	VHA Revenue: VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Culture Barriers.....	17
5.2	Non-VA Care: Payments—VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non-VA Care Claims Timely and Accurately.	20
5.2.1	Major Sub-Findings	20
5.2.2	Major Recommendations	22
5.3	Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.	23
5.3.1	Major Sub-Findings—Information Technology: VHA Revenue	24
5.3.2	Major Recommendations—Information Technology: VA Care Revenue.....	24
5.3.3	Major Sub-Findings—Information Technology: Non-VA Care Payments.....	25
5.3.4	Major Recommendations—Information Technology: Non-VA Care Payments	25
5.4	Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.....	26
5.4.1	Major Sub-Findings—Oversight and Metrics: VHA Revenue.....	26
5.4.2	Major Recommendations—Oversight and Metrics: VHA Revenue.....	26
5.4.3	Major Sub-Findings—Oversight and Metrics: Non-VA Care Payments.....	27
5.4.4	Major Recommendations—Oversight and Metrics: Non-VA Care Payments ...	27
5.5	Additional Considerations.....	28
5.5.1	Holistic, Long-term Planning.....	28

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

5.5.2	Choice Act Implementation	29
5.5.3	Non-VA Care Contracting and Oversight	29
6	Analysis of VHA Revenue	31
6.1	VHA Revenue—Introduction	31
6.1.1	VHA Revenue—History	32
6.1.2	VHA Revenue—Current State	33
6.2	VHA Revenue Assessment Approach.....	35
6.2.1	Data Sources and Analysis	35
6.2.2	Past Findings and Recommendations.....	36
6.2.3	Revenue Operations Strategic Plan	38
6.3	VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Culture Barriers.	39
6.3.1	Insurance Identification—Ineffective and Inconsistent VAMC Processes for Identification of Veteran Insurance Negatively Impacts Third-Party Collections.....	39
6.3.2	Coding and Clinical Documentation—Delays in VAMC Clinical Documentation and Outpatient Coding Backlog Prevent Timely Collections.	46
6.3.3	Cultural Barriers—Veterans and VHA Staff Members Do Not Consistently Understand Veteran Financial Obligations, Resulting in Inconsistent Insurance Identification and Collections.	56
6.3.4	Patient Accounting—Opportunities to Increase Collections Exist.	59
6.3.5	Denials.....	63
6.3.6	Organizational Alignment – Separate lines of accountability for Revenue Processes across VAMCs and CPACs negatively affects collections.....	67
6.3.7	First Party Collections – VHA Could Increase First Party Collections through Financial Education and Point of Service Collections.	69
6.4	Summary of Findings and Recommendations	74
7	Analysis of Non-VA Care Payments	79
7.1	Non-VA Care Introduction	79
7.1.1	Non-VA Care – History	79
7.1.2	Non-VA Care—Current State	81
7.2	Non-VA Care Assessment Approach.....	86
7.2.1	Data Sources and Analysis	86
7.2.2	Past Findings and Recommendations.....	87
7.3	VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non- VA Care Claims Timely and Accurately.....	89
7.3.1	Timeliness – Issues with Paying Claims Timely Exists throughout VHA	89
7.3.2	Accuracy – VHA Payment Accuracy is Lower than Private-Sector Benchmarks.....	93
7.3.3	Findings and Recommendations for Timeliness and Accuracy.....	95
7.3.4	Claims Submission Requirements.....	96
7.3.5	Process for Authorizing Non-VA Care	102
7.3.6	Patient Centered Community Care (PC3)	103

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

7.3.7 Preventing Inaccurate Payments	106
7.4 Penalties – VHA is at Risk for Penalty Payments to Vendors Due to Timeliness Issues.	107
7.4.1 Process for Oversight of Interest Penalties	108
7.5 People	111
7.5.1 Staffing	111
7.5.2 Training	114
7.6 Non-VA Care Summary of Findings and Recommendations	116
8 Analysis of Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.	121
8.1 Introduction	121
8.1.1 Information Technology—History	121
8.1.2 Modernization Efforts.....	122
8.1.3 Key IT Systems Supporting Collections and Payments—Current State.....	123
8.2 VHA Revenue IT Findings	125
8.2.1 Inadequate Technology Prevents Effective Veteran Education, Delays Veteran Payment Plans and Delays Veteran Co-payment Collection.	125
8.2.2 Significant Limitations in the Integration of Tools and Functions Across Clinical and Revenue Management Systems Increase Collection Delays and Denials.	127
8.2.3 Annual CPT® Code Updates are not Implemented Timely Due to Inefficiencies in the Vista Update Process.....	128
8.2.4 VHA Billing Staff are Manually Reviewing 100 percent of Claims Subsequent to Automated Claim Edits, Resulting in Significant Workload and Affecting Billing Timeliness.	129
8.3 Non-VA Care IT Findings	130
8.3.1 Lack of Automation for Non-VA Care Claims Processing (via FBCS) Delays Payments, Causes Inaccuracies, and Increases Improper Payments.	130
8.3.2 Non-VA Care Providers Do Not Have Visibility into the Status of Claims Due to a Lack of Online, Automated Tools.....	133
8.3.3 The Rate of Electronic Claims Submission for Non-VA Care is Low.....	134
8.3.4 The Non-VA Care Claims Processing System is Not Centralized, Leading to Inconsistencies in Standardizing Claims Processing Across VAMCs.	136
8.4 Information Technology Summary of Findings.....	139
9 Analysis of Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.	143
9.1 Introduction	143
9.2 VHA Medical Care—Revenue	143
9.3 Non-VA Care—Payment.....	148
9.4 Summary of Findings and Recommendations	152
10 Conclusion	155

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Appendix A	Background Information.....	A-1
A.1	VA Care, Revenue.....	A-1
A.1.1	Denials.....	A-1
A.1.2	Insurance Verification	A-5
A.1.3	First Party	A-7
A.2	Non-VA Care.....	A-9
A.2.1	Technology to Enable Oversight of Claims Processing Performance	A-9
A.2.2	Overview of Care Authorities.....	A-9
A.2.3	Timeliness by VISN	A-11
A.2.4	Detailed Authorized Care Process	A-12
A.2.5	Detailed Emergent Care Process	A-17
A.2.6	Detailed Information on the Choice Program	A-18
A.2.7	Detailed Information on PC3	A-18
Appendix B	Interviews and Site Visits Methodology Used to Determine Site Visits and Conduct Interviews	B-1
Appendix C	Data Requests	C-1
C.1	Summary of Data Requests.....	C-1
C.2	VHA Revenue Data Requests Detail.....	C-2
C.2.1	Primary Data Requests.....	C-2
C.2.2	Secondary Data Requests	C-3
C.3	Non-VA Care Data Requests Detail.....	C-4
C.3.1	Primary Data Requests.....	C-4
C.3.2	Secondary Data Requests	C-6
Appendix D	Standards and Benchmarks	D-1
D.1	VA Care: Private-Sector Benchmarks and Related VA Standards.....	D-1
D.2	Non-VA Care: Private-Sector Benchmarks and Related VA Standards.....	D-5
Appendix E	References	E-1
Appendix F	Acronyms.....	F-1

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

List of Figures

Figure 1-1. First- and Third-Party Interaction across the Revenue Cycle	2
Figure 3-1. Key VHA Organizations Assessed Relevant to Revenue Collection and Claims Payments	9
Figure 6-1. CPAC & VISN Regional Alignment.....	33
Figure 6-2. Process Areas and Key Components	34
Figure 6-3. Patient Registration Staff Survey.....	41
Figure 6-4. VHA’s Documentation and Coding Process Map for Billable Encounters	48
Figure 6-5. CY 2014 Average Monthly Outpatient Coding Backlog’	53
Figure 6-6. Insurance Capture Error Rate	58
Figure 6-7. Collections Related to Billings – CY2014’	61
Figure 6-8. Reasons for VHA Payment Denials (CY 2014).....	66
Figure 6-9. National First Party Billings and Collections’	70
Figure 6-10. First-party Collections as a Percent of Billings for CY2014.....	71
Figure 7-1. Rendition of Non-VA Care Process Flow.....	80
Figure 7-2 Unique Veterans Served Compared to Total Non-VA Care Spending and Timelines of Key Non-VA Care Events	82
Figure 7-3. Non-VA Care Spending Comparison’	83
Figure 7-4. Designated Sequence Order for Obtaining Care through VHA	86
Figure 7-5. Payment Accuracy Rate by VISN.....	94
Figure 7-6. People, Process, and Technology Tied to Timeliness, Accuracy, and Interest Payments	96
Figure 7-7. CY 2014 Percentage of Submitted Claims Paid’	99
Figure 7-8. Total Paid Claims and Percentage of Penalties	109
Figure 8-1. Decentralized Claims Processing System Inhibits Performance.....	137
Figure 9-1. Gross Days Revenue Outstanding – CY2014	146
Figure 9-2. Claims Paid Volume and Accuracy.....	148
Figure A-1 Average Number of Days to Pay a Claim from Receipt Date for FY 2014.....	A-11
Figure A-2. Vendors Serving in Each PC3 Geographic Region	A-19
Figure A-3. PC3 Reimbursement Process.....	A-21

This page intentionally left blank.

List of Tables

Table ES-1. Processes Assessed by Assessment I Team.....	vi
Table 2-2. Site Visits Performed and Processes Evaluated.....	6
Table 2-3. Interviews, Benchmarks, and Prior Studies	7
Table 6-1. Total First and Third-party Collections, FY2011-2015 (\$ in thousands)	32
Table 6-2. Total MCCF Collections, FY2006-2012 (\$ in thousands).....	32
Table 6-3. Key Components of VHA Revenue Cycle	35
Table 6-4. Previous VHA Care Report Findings.....	37
Table 6-5. Key Intersections with Way Forward Strategic Plan.....	38
Table 6-6. Scheduling.....	40
Table 6-7. Pre-registration and Registration	42
Table 6-8. Clinical Administration.....	46
Table 6-9. Clinical Documentation Latency	48
Table 6-10. Cultural Barriers	56
Table 6-11. Patient Accounting.....	60
Table 6-12. Denials.....	64
Table 6-13. Total Initial Denials Received – CY2014.....	64
Table 6-14. First Party Definition	69
Table 6-15. Summary of Findings and Recommendations.....	74
Table 7-1. Types of Non-VA Care	79
Table 7-2. Previous Non-VA Care Report Findings	87
Table 7-3. Percent of Claims Line Items Paid by Number of Days After Receipt, FY2012 through FY2014.....	90
Table 7-4. Number and Distribution of Non-VA Care Claims In-Process as of February 27, 2015	92
Table 7-5. VHA Timeliness: Percentage of Claims Processed within 30 days.....	93
Table 7-6. VHA Accuracy of Payment	94
Table 7-7. Examples of Billing Differences between VHA and Medicare	97
Table 7-8. Interest Penalties on Late Payments	108
Table 7-9. Summary of Findings and Recommendations	116
Table 8-1. Key VHA Revenue Cycle and Non- VA Care Payment Systems.....	123

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Table 8-2. FBCS Server and Use Summary	137
Table 9-1. Summary of Findings and Recommendations	152
Table A-1. Denial Categories and Recommendations	A-1
Table A-2 VA Copays	A-7
Table B-1. Site Visit Locations and Functions Interviewed	B-1
Table C-1. Team I Joint Data Requests with Other Teams.....	C-1
Table C-2. Team I Solo Data Requests	C-1
Table C-3. Team I Documents Collected	C-2
Table D-1. VA Care Benchmarks and Related Standards.....	D-2
Table D-2. Non-VA Care: Benchmarks and Related Standards.....	D-5

1 Introduction

Assessment I of Section 201, Title II – Health Care Administrative Matters of the Choice Act, or “Veterans Choice Act,” requires an independent assessment of the business processes of the Veterans Health Administration (VHA). Business processes refer to the revenue for **VA Care** (“VHA Revenue”) and payment for private-sector “**Non-VA Care**” services. The business processes used to manage these functions are critical because they affect access, quality of care, and the overall patient experience for our Veterans and their families. This report assesses VHA’s business processes.

VHA, a separate administration with the Department of Veterans Affairs, or “VA,” seeks to achieve key outcomes from this assessment such as improved patient health and well-being, increased patient satisfaction, and increased cost-effectiveness. To do this, VHA must modernize business processes by making improvements in people management, processes, and technological advances.

Health care costs for Veterans are increasing just as health care costs are rising across the industry. The number of Veterans receiving care from VHA has almost doubled since 1997.⁵ In Fiscal Year (FY) 2014, VHA had over \$156 billion in obligations and approximately 325,000 full-time equivalent (FTE). VHA maintains the largest integrated health care delivery system in the United States and provides Veterans with direct care provided by VHA clinicians in a VHA facility (VA Care in this report). In FY 2014, VHA delivered direct VA Care to over 6.4 million unique Veterans, including 600,000 inpatients nationwide at 152 VA Medical Centers (VAMCs), 820 Community Based Outpatient Clinics (CBOC), and several other clinics/centers (VSSC, 2014).^{6,7}

Direct VA Care alone cannot meet all Veterans’ health needs; therefore, VHA outsources and pays for external providers, essentially acting as an “insurer,” for this medically necessary care that is unavailable at VHA facilities (herein referred to as “Non-VA Care”). In 2014, there were approximately 1.2 million unique Veterans treated through Non-VA Care with over 14 million claims valued at \$5.5 billion. According to VA’s CBO, this is a 400 percent increase over the last ten years in Non-VA Care claims. Per the interviews we conducted, Non-VA Care is expected to grow, particularly due to the Veterans Choice Act.

Financial health is critical for the long-term viability of the Veterans’ health care system. To help offset the growing cost of care funded through congressional appropriations; United States Code (USC) 1729, Title 38 provides VHA authority as a provider to seek reimbursement for direct VA Care from third-party payers (e.g., Blue Cross, Aetna, and other insurance companies) for non-service connected treatment. VHA also has the authority to collect co-payments for VA Care from Veterans for non-service-connected⁸ disability medical care. In 2014, VHA billed

⁵VERA Veterans Equitable Resource Allocation 2014, VA Under Secretary for Health, May 2104, Pg 48.

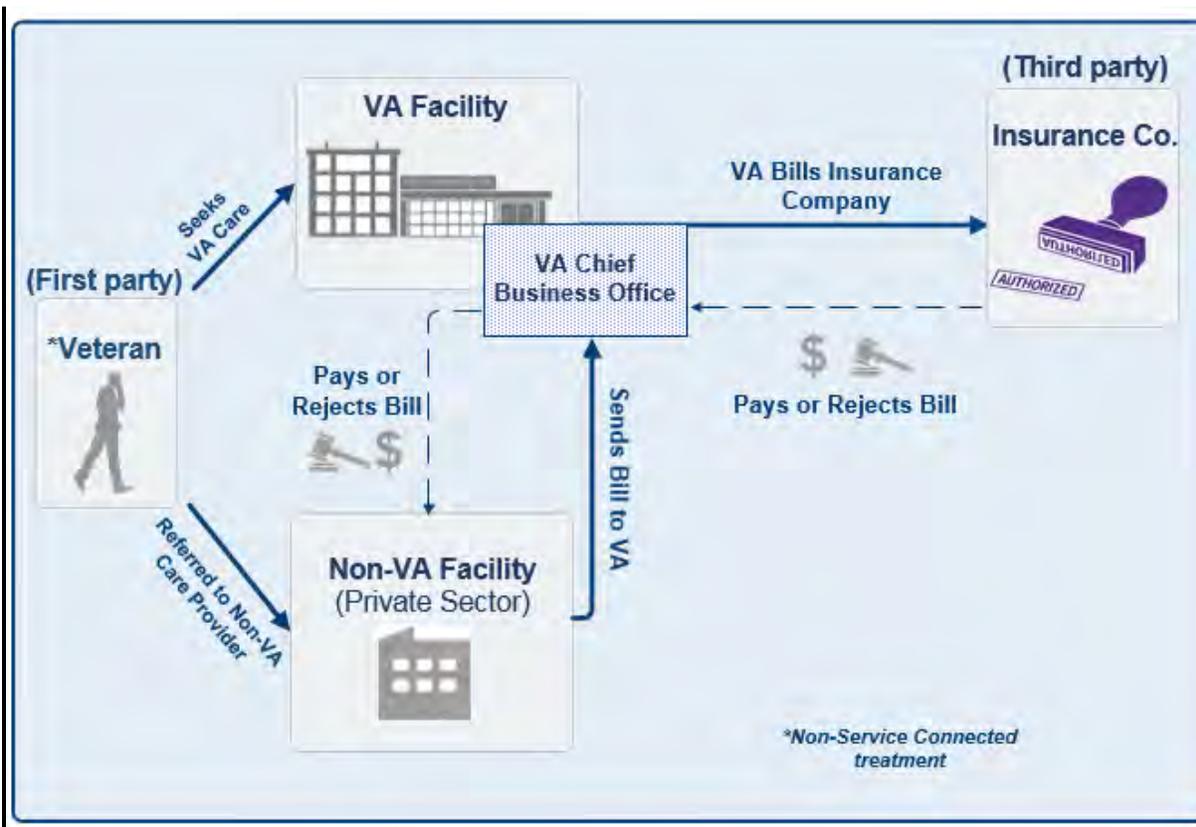
⁶VA 2014 Performance and Accountability Report, VA Office of Management, November 2014, Pg 1.

⁷U.S. Department of Veterans Affairs. (2015, May 11). Where do I get the care I need? [Veterans Health Administration] Retrieved from <http://www.va.gov/health/findcare.asp>

⁸Note: Non-service connected disability medical care refers to care for a Veteran discharged from active military duty without a VA-adjudicated illness or injury incurred in or aggravated by military service.

approximately \$6 billion for VA Care and collected almost \$3.2 billion from third-party reimbursements in accordance with USC 1729, Title 38. In 2014, VHA collected an additional \$85 million from Veteran (first-party) co-payments. Figure 1-1 illustrates the business process flow for both VA and Non-VA Care.

Figure 1-1. First- and Third-Party Interaction across the Revenue Cycle⁹



Source: Grant Thornton’s rendition of VHA’s Business process flow

As the largest integrated health care delivery system in the country, VHA has a multitude of challenges driven by the organization’s size, magnitude of care and services, and geographical dispersion. To compare with a private-sector provider considered one of industry’s best in class, Kaiser Permanente is responsible for millions of “lives,” similar to VHA. In contrast with VHA, Kaiser’s responsibilities are concentrated in a few distinct areas, while VHA’s responsibilities are geographically dispersed across the country, in Puerto Rico, the Philippines, and other locations where Veterans live abroad. This assessment provides insight into VHA financial management by focusing on business process challenges and identifying opportunities to increase revenue reimbursement collection for direct VA Care and to minimize payment issues to external Non-VA Care providers.

⁹Note: Under the Veterans Choice Act, the Non-VA Provider also bills Third Party Insurance.

1.1 Scope

As defined in Paragraph (I), Section 201, Title II – Health Care Administrative Matters of the Choice Act legislation, *Business processes of VHA includes processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:*

- i. To avoid the payment of penalties to vendors*
- ii. To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate*
- iii. To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate*
- iv. To increase the accuracy and timeliness of Department payments to vendors and providers*

To meet the legislation, Assessment I (Business Processes) established goals and identified questions to determine the effectiveness of and identify improvement opportunities for VHA financial management of payments, reimbursements, and collections for VA and Non-VA Care processes.

Note: Throughout this report, the term “providers” refers to physicians, and “clinicians” is the broader reference to physicians, nurses, therapists, and medical professionals.

1.2 Assessment I Relationships to Other Assessments

Assessment I (Business Processes) has relationships with other assessment areas due to overlapping processes and tools that required cross-assessment coordination and collaboration. As appropriate, we refer to the following assessment reports for further analysis and additional details.

- **Assessment C—Care Authorities:** Assessed the legislative mandates and VA/VHA directives that drive many of the required processes for revenue collection and claims payments. We coordinated with C to address relevant Non-VA Care drivers and constraints.
- **Assessment E—Workflow – Scheduling:** Assessed the processes for scheduling appointments at each medical facility. Scheduling, part of the Patient Intake process, directly affects the collection of Veterans’ insurance and other information needed to collect the Veteran co-payments and third-party reimbursements in Assessment I’s scope.
- **Assessment F—Workflow – Clinical:** Assessed the workflow processes and tools for inpatient medical services and care. Clinical coding and documentation workflow processes and tools affect third-party reimbursement collections for VA Care under Assessment I (Business Processes).

- **Assessment H—Health Information Technology:** Assessed the IT strategies that support clinical documentation and enterprise-wide applications for management of care and business operations. IT and automation support are essential for I’s business processes.

1.3 Limitations

This assessment has several important limitations including that we conducted the assessment under an abbreviated timeframe, conducted a small sample of site visits, and were limited to the data available from VHA. We interviewed stakeholders at all levels of the agency across both the Chief Business Office (CBO) and VHA. While this approach offered tremendous insight, we recognize that the perspectives are limited to the sample of stakeholders.

As described in Chapter 7, this assessment was conducted during a period of significant change in organizational responsibility for Non-VA Care. Section 106 of the Veterans Choice Act “[transferred] the authority to pay for hospital care, medical services, and other health care furnished through non-Department of Veterans Affairs providers from the VISN and medical centers of the Department of Veterans Affairs, to the CBO of the Veterans Health Administration of the Department of Veterans Affairs.”¹⁰ The implementation resulted in the consolidation of Non-VA Care claims processing staff, provides the CBO with the authority to standardize processes and procedures to pay Non-VA Care claims, and enforce related rules and regulations across VAMCs nationally. As the timing of our assessment coincided with this transition, we encountered business processes that were in varying stages of centralization, redesign, and standardization. Our approach was to assess the current state of business processes, while providing perspectives into VHA’s planned and ongoing transition activities. We also note that due to timing, most of our data analysis did not contain substantive data on business processes as impacted by the Choice Act. Our data largely reflects the legacy structure and responsibilities for Non-VA Care.

¹⁰Veterans Access, Choice, and Accountability Act of 2014

2 Methodology

Our methodology includes analytical principles supported by sound evaluation, process assessment, and qualitative data collection practices that led to evidence-based findings. We conducted discovery and analysis activities, generated findings and developed unbiased, data-driven conclusions, and made recommendations to improve VA's business processes. Our methodology has three phases: Planning and Discovery, Site Visit and Data Analysis, and Findings and Recommendations.

2.1 Phase 1: Planning and Discovery

Design Assessment: We conducted a broad-based examination of the business processes and identified areas of potential risk and opportunities for improvement. Key activities include:

- Analyzed legislation requirements and identified key study areas.
- Defined the baseline environment of current processes and IT infrastructure and identified anticipated, future needs driven by process and technical improvements.
- Identified qualitative and quantitative assessment effects on engagement, revenue billing, clinical data exchange, experience of providers, and relevant Veteran experience.

We also conducted an analysis that focused on the assessment activities, prioritized our efforts, and validated all activities. Key activities include:

- Designed site survey assessments to highlight commonalities and gaps, and on-site assessments to develop a first-hand understanding and the ability to answer questions and conduct interviews.
- Identified commercial benchmarks that most closely align to VHA business processes and analyzed gaps between VHA and commercial processes.
- Coordinated with VHA to provide input and validate our assessment design and process. Revised the design to meet the people, technology, and process objectives.

Discovery and Data Collection: We identified data sources and information required to conduct the assessment, including necessary policies, procedures, organizational information, prior assessments, audit reports, operational information, key performance indicators, and other required information. Our data findings are based on available VHA data for the years 2012 to 2014. In coordination with VHA stakeholders, and thanks to their proactive and responsive efforts, we obtained about 90 percent of the data we requested. The remaining datasets we requested either were not fully available or did not exist. Refer to Appendix C for more background on our data requests. We also conducted a VAMC-wide data call for insurance capture buffer exceptions to assess advance insurance verification for scheduled patients and pre-registration rates to measure progress in collecting required patient information at time of check in. We were very successful with the data call and received an 88.5 percent response.

Despite the magnitude of recent analyses and reports previously completed for VHA, we carefully reviewed the data and information we collected related to VHA's business processes. Refer to Appendix E for the listing of VA Care and Non-VA Care reports that we reviewed.

Assessment I (Business Processes)

During this phase, we established criteria and selected the sites, as summarized in Table 2-1, to visit for our assessment. The condensed timeframe of this assessment required that we use a sampling approach based on our selection criteria. Refer to Appendix B for additional details.

Table 2-1. Site Selection Criteria

Team	Criteria
VA Care	<p>Consolidated Patient Account Center (CPAC)</p> <ul style="list-style-type: none"> • 1 Small, 1 Medium, and 1 Large based on claims volume <p>VA Medical Center (VAMC)</p> <ul style="list-style-type: none"> • 4 VAMCs supported by CPACs above and/or a range of performance on VHA metrics
Non-VA Care	<p>1 Health Administration Center (HAC)</p> <p>VAMC—1 High Performing (High Volume of Claims, Exceptional Timeliness Metrics)</p> <p>VAMC—2 Average Performing (both accuracy and timeliness)</p> <p>VAMC—1 Low Performing VAMC (High Interest Rates, Poor Timeliness)</p>

2.2 Phase 2: Site Visit and Data Analysis

Our team evaluated the people, process, and technology aspects of VHA Revenue and Non-VA Care Payment business processes. As part of each assessment, we conducted document reviews, data analyses, site visits, interviews, and process walkthroughs.

Site Visits: We conducted site visits at the seven VAMCs, three CPACs, and HAC, and examined key functions for both VA Care and Non-VA Care processes as shown in Table 2-2. As part of the site visits, our team conducted interviews with process performers, clinicians, and business managers. We developed our interview questionnaires for our site visits based on industry standards, protocols, and best practices.

Table 2-2. Site Visits Performed and Processes Evaluated

Process	Sites	Key Functions
VA Care	3 CPACs	Billing and Collections
VA Care	4 VAMCs	Scheduling, Registration, Insurance Capture, Documentation, and Coding
Non-VA Care	1 HAC	Non-VA Care Guidance, Policy and Procedures, Training, and Data Analytics
Non-VA Care	4 VAMCs	Non-VA Care Authorization, Receipt of Claim, Processing (e.g., Edit checks, Pricing), and Payment

Data Analysis: In addition to the site visits, we conducted a series of expert stakeholder interviews, reviewed VA materials such as policy documents, organization charts, and standard operating procedures, analyzed and compared VHA performance against relevant industry

Assessment I (Business Processes)

benchmarks, and reviewed and analyzed previous studies and reports for additional insight into issues, best practices, and potential process improvements.

We tracked, collected and analyzed 77 documents and datasets from our VHA stakeholders, and collected another 645 documents from our own search efforts. We also reviewed and analyzed 54 documents and datasets that we collected through joint requests with other teams. Through these efforts, we obtained Performance and Operations Web-Enabled Reports (POWER) and Informatics reports with volumes of performance and financial data, which we analyzed and compared against the benchmarks and VHA standards. We also analyzed the insurance capture and verification data we received from the VAMC-wide data call. Table 2-3 summarizes the activities we conducted for this assessment. Refer to Appendix D for more detail on standards and benchmarks.

Table 2-3. Interviews, Benchmarks, and Prior Studies

Interviews and Site Visits Conducted	Executive Leadership	<ul style="list-style-type: none"> • Chief Business Office, including Revenue Operations and Purchased Care • Health Net Federal Services and TriWest • Health Information Management Service (HIMS)
	Site Visits	<ul style="list-style-type: none"> • Visited 3 CPACs, 1 HAC, and 8 VAMCs • Interview 63 staff members for VA Care • Interviewed 44 staff members for Non-VA Care • Conducted 30 process walkthroughs
Analysis of Industry Benchmarks	VA Care	<ul style="list-style-type: none"> • Healthcare Financial Management Association (HFMA)
	Non-VA Care	<ul style="list-style-type: none"> • American Health Insurance Plans (AHIP) • American Medical Association (AMA) • RSM McGladrey • Medicare/Medicaid
Analysis of Previous Studies	VA/Non-VA Care	<ul style="list-style-type: none"> • Office of Inspector General (OIG) Reports • Government Accountability Office (GAO) Reports • Internal VA Oversight Reports (e.g., Internal Controls, Improper Payments) • Industry White Papers (e.g., National Academy of Public Administration)

Benchmarks and VHA Standards: For VA Care revenue collection processes, we used the private-sector Healthcare Financial Management Association’s (HFMA) benchmarks and best commercial practices for evaluating VHA performance, to the extent possible. For example, we used payment denial rates as a benchmark in our evaluation. If required, and possible, we adjusted the data in order to conduct an “apples-to-apples” comparison. For VHA data/metrics that could not align to commercial metrics, we used VHA standards of performance for our analysis. For example, VHA metrics for coder productivity did not fit the HFMA benchmark, so we used VHA’s standard for coding turnaround time for our evaluation criteria. For more detail, refer to Appendix D.

For Non-VA Care, we used the private-sector American Health Insurance Plan (AHIP), American Medical Association (AMA), RSM McGladrey, Medicare and Medicaid benchmarks to the extent

possible. For payer-related benchmarks, we sought to include Sherlock data¹¹ in our assessment, but were unable to obtain the necessary licensing rights. We adjusted VHA's data for a good comparison against the industry benchmarks, as needed. We used VHA's standards when we could not make an adequate comparison. We examined process metrics including payments, accuracy, timeliness, interest payments, and mode of claims submissions. Refer to Appendix D for more detail on standards and benchmarks.

2.3 Phase 3: Findings and Recommendations

In this phase, we analyzed the collected data, comparing VHA data against previous studies and industry benchmarks, and evaluated the interviews and site visits results to identify findings and potential recommendations. We synthesized our findings to highlight those that are most important and developed strategic and tactical recommendations. We based these recommendations on best practices and industry standard practices used by other providers to improve their processes and outcomes.

We reviewed and analyzed several GAO, VA OIG, and prior studies and investigations conducted to evaluate VHA revenue collection and claims payment processes. Several findings in our report reflect historical issues as identified in previous reports. We conducted specific root-cause analyses of these findings and went beyond strategic, high policy-level guidelines typically found in prior reports and identified tactical-level, actionable recommendations that assist with near-term, incremental improvements.

We also considered input from an independent Blue Ribbon Panel, comprised of executive-level health care industry leaders, who provided expert opinion and input throughout the assessment activities. The panel members possessed a thorough understanding of health care industry best practices and provided advice and feedback on the emerging findings and recommendations.

The results address performance across VHA business processes to improve revenue and payment with key recommendations to help achieve critical outcomes of improving the Veteran experience, decreasing Veteran medical costs, and ensuring the long-term viability and success of VHA's Veteran health care program.

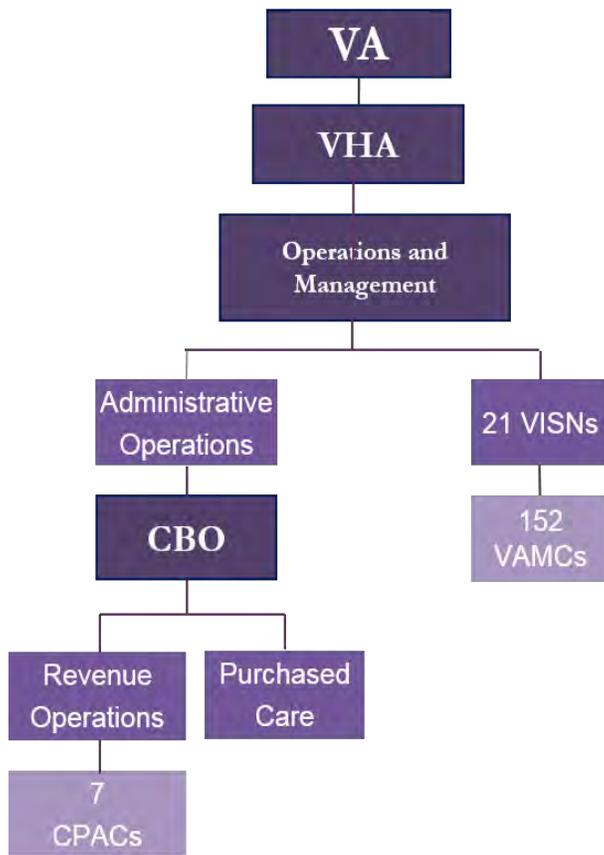
¹¹ Note: Sherlock is a well-known, industry standard used by large insurance plans, Medicare and others for benchmarking, staffing and budgeting.

3 Key Organizations and Stakeholders Examined

Several key VHA organizations have major roles and responsibilities to execute and oversee the business processes related to collections for VA Care and claims payments for Non-VA Care. This section identifies and explains the key organizations that influence VHA’s business processes related to revenue and payment.

Figure 3-1 illustrates the key VHA organizations and the following paragraphs describe their related roles in more detail.¹² VHA is a separate administration under VA. Within VHA, the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM) leads VHA operations and operates VHA health care systems, VAMCs, systems of clinics, and outpatient clinics. The Assistant DUSH for Administrative Operations manages 12 components that provide administrative and operational support services for the VHA health care system, with the CBO being most relevant for this assessment.

Figure 3-1. Key VHA Organizations Assessed Relevant to Revenue Collection and Claims Payments



Source: Grant Thornton’s rendition of key VHA organizations that are relevant to revenue collection and claims.

¹² Note: VA 2014 Functional Organizational Manual—v2.0a, Description of Organization Structure, Missions, Functions, Tasks and Authorities, is the primary source for the summarized information in this section.

3.1 Chief Business Office (CBO)

Located in Washington, D.C., the CBO is responsible for all VHA Business Operations, including Purchased Care and Revenue Operations. The CBO develops policies, procedures, and training for VAMCs and provides overall direction and guidance for advancing business practices that support patient care and health benefits delivery. This group is responsible for compliance with business standards and requirements, including implementing appropriate internal controls and performance measures. The CBO manages three business lines: Revenue Operations, Purchased Care, and Member Services with the first two relevant to this assessment.

3.1.1 CBO Revenue Operations

The CBO Revenue Operations business line manages the following responsibilities:

- Administering first- and third-party collections
- Developing and providing overall direction, guidance, procedures, and training for the CPACs
- Standardizing processes and providing technical expertise in revenue processes
- Conducting metric-based, operational analysis.

Revenue Operations is also responsible for eBusiness Solutions and Business Information, not shown above. The Office of eBusiness Solutions develops and implements leading electronic Data interchange applications throughout VHA. The Business Information Office provides data and analysis to support VHA's legislative and process-improvement initiatives.

Consolidated Patient Account Centers (CPAC) – The CPACs standardize and coordinate activities related to billing and collections for all health care services furnished to Veterans for non-service-connected medical conditions. The CPACs are chartered to apply commercial industry standards for measures of access, timeliness, and performance metrics with respect to revenue enhancement of the Department.¹³ The CPACs generate bills from VAMC-coded non-service connected disability health care admissions and encounters, send them to third-party insurance carriers, then collect and process payments. To improve coordination and communication between the VAMCs and the CPACs, staffs are located in the facilities as well as each regional CPAC. CPACs perform back-end revenue processes while each of the VAMCs maintain ownership of key Veteran-facing revenue functions.¹⁴

CPACs perform back-end revenue accounting processes, while VAMCs own key front-end Veteran-facing functions.

There are seven CPACs assigned to cover different regions throughout the country. The CPAC locations are: Asheville, NC (Mid-Atlantic—MACPAC); Middleton, WI (North Central—NCCPAC); Smyrna, TN (Mid-South—MSCPAC); Lebanon, PA (North East—NECPAC); Orlando, FL (Florida &

¹³ Public Law 110-387, Section 406.

¹⁴ VA 2014 Functional Organizational Manual—v2.0a, Description of Organization Structure, Missions, Functions, Tasks and Authorities, Pg 133.

Caribbean—FCCPAC); Leavenworth, KS (Central Plains—CPCPAC); and Las Vegas, NV (West—WCPAC). Additional background and history of the CPAC is located in Section 6.

3.1.2 CBO Purchased Care (CBOPC)

Located in Denver, CO, CBOPC is the center of external Non-VA Care and associated claims payment processes. CBOPC is responsible for the delivery of health care benefits through enterprise program management and oversight of Purchased Care functions. This includes overall management of Health Care Payer Programs, including development, implementation and oversight of legislative, regulatory, and policy standards for the program areas. CBOPC oversees the Non-VA Medical Care (Fee) Program and manages business and systems support for the program areas.

- CBOPC is responsible for the development of administrative processes, policy, regulations and directives associated with the delivery of the Non-VA Care program. Section 106 of the Veterans Choice Act directed VHA to transfer the authority to pay for hospital care, medical services, and other health care furnished through Non-VA providers from the VISN and VAMCs to the CBO. CBO is now responsible for all claims processing and payment operations and staff. Supervisors and claims clerks manage and conduct the day-to-day activities of the Non-VA Care program. These activities include scanning claims, reviewing administrative eligibility, processing claims for payment, answering Non-VA provider inquiries.

CBOPC manages offices responsible for the following activities:

- Administering VistA Fee, Central Fee, Fee Payment Processing System, and Fee Basis Claims Systems (FBCS)
- Developing and maintaining contractual relationships with Non-VA (private-sector) providers, including Patient-Centered Community Care (PC3) relationships
- Processing claims and payments, and adjudicating benefits.

3.2 Veterans Integrated Service Networks (VISN)

VHA designed VISNs to be the basic budgetary and planning unit of the VHA. There are 21 VISN offices organized by geographic regions throughout the country, with each VISN providing a shared system of care to provide Veterans better and greater access to care. Each VISN delivers medical care through a network of VAMCs, CBOCs, and related facilities located within their geographic region. Each VISN has budget and administrative responsibilities, including contract services, long-term care, sharing-agreements, and operational oversight for associated facilities.

3.2.1 Department of Veterans Affairs Medical Center (VAMC)

There are 152 VAMCs functioning as the primary care delivery operations within VA's structure.¹⁵ Each VAMC is associated with a VISN in its geographical region and supported by a regional CPAC. As it relates to revenue collection, VAMCs are responsible for the patient registration, scheduling, clinical documentation, and coding.

- When VAMCs are unable to provide the needed care, VAMCs refer Veterans to private-sector providers, often referred to as "Non-VA providers." VAMC clinicians generate the referrals for Non-VA Care. VAMC authorization staff members are responsible for reviewing these referrals, creating authorizations, and scheduling appointments for Veterans in the community.

¹⁵ U.S. Department of Veterans Affairs. (2015, May 11). Where do I get the care I need? [Veterans Health Administration] Retrieved from <http://www.va.gov/health/findcare.asp>

4 Best Practices

VHA has seen significant opportunities for improvements across business processes. Our site visits and interviews revealed several best practices across VHA. We conducted root cause analyses for sites where performance results significantly exceeded VHA averages. VHA should examine these peer organizations' best practices to determine applicability across other sites. This section summarizes some of the proven ideas and initiatives that could help VHA achieve some needed process improvements throughout the organization. This section also includes recommendations that can help "institutionalize" these improvements throughout VHA.

4.1 Identified Best Practices

- 1. Nation-wide implementation of CPAC structure following successful MACPAC pilot: VHA opened the first Consolidated Patient Account Center (CPAC) in October 2009 as a successful pilot facility.**
 - Following successful implementation of the MACPAC, all VAMCs transitioned their Patient Accounting operations to one of seven CPACs. The transition to the CPAC structure is industry-modeled to centralize and enhance billing and collection activities. The consolidation of traditional revenue program functions into regionalized centers closely aligns VHA billing and collections activities with industry best practices. The CPAC consolidation enabled VHA to structure and standardize key billing and collection functions.
- 2. Non-VA Care claims timeliness improved due to new workload distribution approach.**
 - Sixty days after implementing the Fee Basis Claims System (FCBS), the Minneapolis VAMC within VISN 23 had a backlog of claims exceeding 30 days as the FCBS process required claims distributed alphabetically to each processor. By changing the process and giving the supervisor control over the flow and distribution of claims, the unit optimized productivity as the supervisor assigned claims to processors based on workload.
- 3. Although manual, pre-authorization and pre-payment reviews reduced Non-VA Care error rates.**
 - To ensure accuracy of claims payment, the Minneapolis VAMC developed a workaround to conduct pre-authorization and pre-payment reviews of each claim. In the absence of an ideal automated solution, the workaround resulted in an FY2014 error rate of less than one percent.¹⁶ When the pre-authorization and pre-payment reviews identify errors, a supervisor works with the clerk to provide corrective training and ensure finalization of the payment. This process, although manual, is beneficial until automation of the claims payment process is achieved. The end state best practice is for an automated review with the appropriate analytics followed by a manual review of a sample of claims to achieve an error rate of less than one percent. Note that these claims reviews require subject matter expertise on the Non-VA Care program.

¹⁶ Note: The error rate of less than one percent was identified by using raw data from the 2014 IPERIA report.

4. High and Accurate VAMC Insurance Capture Rates Improved Associated CPAC Revenue Collection.

- Through an evaluation of our site visits and compiled data, we noted three CPACs and their supported VAMCs were using specific leading practices regarding VAMC insurance capture processes to enable better revenue collection performance. The MACPAC in Asheville, NC, the NCCPAC in Middleton, WI, and the FCCPAC in Orlando, FL, had the lowest error rates in insurance capture (based on a VAMC-wide data call) and, as a result, are leading performers in revenue collection. Insurance identification errors are missed opportunities for VAMC Patient Intake clerks to capture Veteran's insurance information.
 - *Centralized check-in and VAMC leadership support improves insurance identification:* The Asheville VAMC conducts insurance identification through a centralized check-in station allowing patients to register in one location. The Asheville VAMC Director requires all patient intake clerks to ask for third-party insurance cards at the central check-in station. In reviewing Asheville's collections-to-billings indicator, they are performing at 52.2 percent, which significantly exceeds other VAMC's 35–45 percent performance range. The use of centralized check-in and the VAMC Director's support of insurance capture requirement contribute to high collections-to-billing performance at the associated CPAC and is consistent with industry practice.
 - *CPAC and VAMC insurance identification monitoring improves performance:* VISN 8 in North Florida/South Georgia developed an insurance identification report that monitors insurance capture by VAMC department and patient intake clerk.¹⁷ VAMC management monitors this report to identify and correct low insurance identification performers and resolve the insurance capture challenges. In reviewing performance indicators, the FCCPAC is the third best CPAC in insurance capture performance and collections as a percent of billings performance metrics. The regular VAMC use of insurance identification tools positively affects CPAC performance in billings and collections.
 - *CPAC and VISN teaming streamlines Accounts Management workflow processes to improve revenue collection:* The NCCPAC Accounts Management team teamed with VISN 10, 11, and 12 to create a structure that assigns Accounts Management clerks to specific VISNs within the CPAC. This allowed CPAC staff to improve communication and coordination with VAMC Patient Intake staff. CPAC Accounts Management staff achieved a better understanding of the specifics for a particular VISN (e.g., facility revenue, payers and specific denials) and, as a result, addressed issues better and more quickly. The Accounts Management team also generates site-specific data reports to identify tactical challenges. The streamlined workflow processes are a best practice that contributes to NCCPAC's performance as second of all CPACs at insurance capture and the best at collections to billings.

¹⁷ Note: Most VAMCs do not monitor insurance capture by department or patient intake clerk; VAMCs typically monitor insurance capture by site.

4.2 Recommendations for Expanding Best Practices

As described in Section 4.1, our site visits and interviews revealed several best practices for VAMCs, CPACs, and VISNs; however, the national adoption of these best practices is inconsistent. We recommend that VHA develop mechanisms for regular examination of best practices to determine where successful practices apply and implement these practices across similar VHA business functions. For example, VHA and CBO should leverage existing PMO meetings across both Purchased Care and Revenue Operations to include an action item to identify, share, and institutionalize best practices across VHA. Sharing and institutionalizing best practices will allow VHA to improve upon them as business processes continue to evolve.

This page intentionally left blank

5 Overarching Findings and Recommendations

5.1 VHA Revenue: VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Culture Barriers.

This finding relates to the billing and collection processes associated with the direct medical care VHA provides in its facilities (VA Care). Commonly referred to in industry as the “revenue cycle,” the requisite processes are - *Patient Accounting* (Billing and Accounts Management), that are highly dependent on activities that include *Patient Intake* (Scheduling, Pre-registration, and Registration), and *Clinical Administration* (Clinical Documentation and Coding). At VHA, the VAMCs are responsible for the Patient Intake and Clinical Administration activities while the CPACs own and execute the Patient Accounting activities. From beginning to end, all parts of the revenue cycle must be coordinated to effectively and properly bill and collect revenue from insurance companies (third party) and co-payments from Veterans (first party) for non-service connected medical treatment.

As the cost of Veteran care continues to rise, increased emphasis on collections is integral to ensure long-term financial viability for the Veterans’ health care program. VHA opportunities to increase collections offers a stark contrast between a disciplined and coordinated private-sector revenue cycle and the revenue cycle that VHA employs.

Major Sub-Findings

The following points summarize the root causes and major sub-findings that contribute to this overarching finding. Chapter 6, VHA Revenue, includes the detailed analyses, evidence, and data sources required for a more complete understanding.

- **Ineffective Insurance Identification and Verification:** The current process is for VAMC Patient Intake staff to ask for insurance information from the patient. Once insurance is identified, the CPAC insurance verification teams verify insurance coverage (patient dates of eligibility, service coverage, and pre-certification/authorization requirements). When insurance is not identified appropriately, this results in CPAC staff collecting and verifying the patient’s insurance “after-the-fact.” Ineffective insurance identification and verification of insurance during the Patient Intake results in delayed insurance verification by CPAC staff and denials from insurers. Accurate Veteran insurance identification is a key predecessor to bill and collect payments from third-party insurers. This current process has led to significant collection delays and denials. For example, in 2014, 54.6 percent of denials were related to the Patient Intake function, with non-covered charges representing the largest (35.8 percent) portion.
- **Delays in Coding and Clinical Documentation:** Delays in VAMC clinical documentation and outpatient coding impede timely revenue collection. Clinical documentation and coding drive the services and amounts necessary to bill and collect from insurers. Delays in clinical

documentation across VHA, coupled with a lack of certified coders, reduce collections. In 2014, clinical documentation and coding issues were associated with \$14.2 million in denials. VHA has not mandated participation in the national Clinical Documentation Improvement (CDI) program to improve documentation practices and fewer than half of VAMCs have a CDI program. Inadequate documentation forces VHA Coders to exhaust energy and resources rectifying gaps in documentation. This results in coding backlogs. VHA is also at risk for ICD-10 readiness if clinicians are not trained on documentation requirements, and coders are too busy to keep up.

- **Longstanding Cultural Barriers:** According to interviews with VAMC leadership, Veterans and VHA staff do not consistently understand Veterans' financial obligations, resulting in inconsistent insurance identification and co-payment collections. Congress gave VHA authority to collect reimbursements for direct VA Care from third party payers and to collect co-payments for non-service connected care. Many Veterans believe they are entitled to "free care for life," some VHA staff are uncomfortable asking for insurance or do not believe it is appropriate to bill insurance for Veteran care. Based on feedback from VAMC leadership, culture barriers prevent VHA from maximizing collections due to Veterans not always understanding the need to provide insurance information and reluctance from VHA staff to ask for it.
- **Organizational Challenges:** Separate lines of accountability for revenue processes across VAMCs and CPACs negatively affects collections. VHA executes Patient Intake, Clinical Administration, and Patient Accounting business processes across the VAMC and CPAC. However, only the CPACs are accountable for revenue collection and the associated performance outcomes.
- **Ineffective First- Party Collections:** Lack of one-on-one interaction with the Veteran during registration/check-in processes to offer financial education inhibits VHA's ability to increase first-party collections. Veterans who do not understand why and how much they owe for non-service connected treatment are less likely to pay owed amounts.

Major Recommendations

The following recommendations are key actions and process improvements that VHA should take to address the long-standing, systemic issues with revenue cycle processes to achieve enhanced, overall performance, increase revenues, and, ultimately, increase Veteran satisfaction.

- **Identify Insurance Information at VAMCs:** VHA should immediately mandate and incentivize all VAMCs to identify insurance and obtain signed release of information as necessary during the Patient Intake process. VHA should document best-practice insurance capture guidelines and incorporate them into standardized procedures. CPACs should assign and co-locate a Facility Revenue Technician (FRT) with the VAMC Patient Intake clerks to assist with insurance questions and financial questions. VAMCs and CPACs should monitor

the best practice reports to identify progress and proactively work issues. For the longer term, VHA should enhance kiosk functionality to identify and verify insurance.

- **Enforce Clinical Documentation Requirements:** VAMCs should enforce the existing policy that directs 24-hour turnaround for all clinical documentation and encounter closeouts. VAMCs should use performance pay agreements to assist with enforcing and rewarding clinician compliance. VHA should also standardize the CDI program and mandate use across all VAMCs. VHA should provide designated CDI specialist funding to VAMCs to enable use of this essential role. VHA should also use the CDI program to enhance ICD-10 readiness and implementation.
- **Minimize Cultural Barriers:** Near-term actions include increasing communication to Veterans and VHA staff through an immediate push using VAMC Town Hall meetings, website resources, and existing staff and Veteran training as mechanisms to emphasize the insurance collection requirement. Include this education in mandatory, periodic refresher training for all VHA staff. To address the larger cultural barriers, VHA should incorporate education of Veterans, their families/caretakers, all levels of VHA staff, key stakeholders (including Congress and state/local government agencies, Veterans' groups), and the public into their Strategic Communications Plan. The education should focus on the legislative requirements for third-party insurance identification and collection to support the long-term financial viability of VHA's health care program.
- **Assign Revenue Accountability to VAMC/VISNs:** VHA should assign VAMCs shared responsibility with the CPAC for revenue outcomes and include specific goals in management/staff performance plans as a near-term improvement. Longer term, an emerging practice in private-sector health care is to align all components of the revenue cycle under the Chief Financial Officer (CFO) linking job responsibilities to financial performance. VHA's revenue cycle activities currently owned by the VAMC/VISN are Scheduling, Pre-Registration, Registration and Coding—all primary functions for identifying and verifying insurance, and ensuring accurate and timely first- and third-party collections. The private sector has recognized that aligning these functions under a single organization improves accountability and revenue cycle performance. Our findings indicate that the separation between business process and organizational structure within the VHA revenue cycle processes has resulted in a lack of coordination and consistency in these functional areas. Given the size and complexity of VHA compared to the private sector, any realignment needs to be carefully considered. Added to this, the VHA CBO recently completed a very large organizational consolidation of Non-VA Care employees and adding significantly more responsibility to the CBO at this time may be difficult for the CBO to absorb in the near-term.
- **Reduce Complexity of Rules:** Congress and VHA should undertake a complete review of the Veteran eligibility, service connection, non-service connection and benefits rules and

categories in order to develop a single, comprehensive, easy-to-understand set of guidelines that align with industry standards (where possible). VHA should support automated business rules and enforce simplified rules that are understandable and implementable by staff at all levels. In addition, we believe that the complex billing processes require higher graded staff levels for billers than the GS5 level currently employed.

- **Automate and Integrate Technology:** VHA must recognize and allocate sufficient funding to acquire and implement the automated technology needed to address the significant manual-process issues that plague and prevent VHA from achieving the needed improvements in revenue collection. The technology needs to integrate dependent functions (front, middle, and back end) to execute routine business processes seamlessly across functional areas.

5.2 Non-VA Care: Payments—VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non-VA Care Claims Timely and Accurately.

This finding relates to VHA payments for private-sector (Non-VA) care when required care is not available in VHA facilities. Infrastructure, in this finding, includes the lack of documented guidelines and procedures, inadequate technology and tools, insufficiently trained staff, and an inadequate number of staff. Private-sector providers (herein referred to as Non-VA Care providers) submit claims to VHA for the authorized care they provide to Veterans and VHA is required to process and pay those claims. Non-VA Care claims processes are complicated significantly by the number of multiple parties, complex procedures, and manual tasks required. Inadequate technology has a major effect on the outcome of these processes due to the volume and manual nature of work required. In 2014, VHA processed 14 million claims, which could rise to 19 million claims in 2015 if the trend continues.

The effective execution of Non-VA Care activities, both from timeliness and accuracy perspectives, is essential to maintaining the network of providers necessary to keep America's health care promise to our Veterans.

5.2.1 Major Sub-Findings

The following list summarizes root causes and major sub-findings that contribute to this overarching finding. Timeliness, accuracy, and penalties are addressed first, followed by the infrastructure and related challenges. Chapter 7, Non-VA Care, includes the detailed discussion, evidence, and data sources required for a more complete understanding.

- **Accuracy and Timeliness Issues:** VHA has widespread, significant issues with payment accuracy. Only six of 21 VISNs met VHA's standard and industry benchmark for payment accuracy. Since 2009, VHA improvements have increased accuracy rates from 83 percent to 91 percent in 2014; however, that is still lower than the VHA standard of 98.5 percent. Two

VISNs, different than the VISNs with timeliness issues, are well below the average rates at 78 and 83 percent accuracy rates. The same underlying issues with infrastructure, technology and process complexities discussed above also apply.

Issues exist with paying Non-VA Care claims timely. The backlogs, as detailed in Chapter 7, reflect this. Additionally, the manner in which VHA tracks payment timeliness is not entirely reliable. For example, there are indications that due to the claims backlog, claims are not date-stamped timely. Consequently, this affects the ability to assess timeliness performance accurately. According to VHA-provided data, 16 percent of claims (approximately 239,000) are 31-60 days late and 1 percent (approximately 12,000) are more than 180 days late, causing significant financial effect to select providers.

- **Penalties Assessed:** VHA mechanisms to avoid penalty payments to vendors are inadequate. Currently, VHA's interest penalties are minimal; in 2014, VHA incurred \$292,217 in interest penalties on \$5,580,590,777 of paid claims, however, VHA's payment practices are under review by VA's Office of General Counsel (OGC). If OGC finds that VHA must pay back interest, then it will be significant based on conducted interviews. VHA tracks interest penalties at the national level and does not consistently communicate interest penalties down to the CBO staff at the VAMCs. Improvements are necessary in payment timeliness and accuracy to avoid penalties that will accrue for late and inaccurate payments.
- **Inadequate Non-VA Provider Guidelines:** Inadequate Non-VA Care claims submission guidance prohibits widespread use of electronic claims submission and increases workload and payment errors. Non-VA Care providers only submitted 28.6 percent of their claims electronically for fiscal year 2014, significantly less than the 94 percent of electronic claims for commercial payers. High levels of paper claims affect accuracy and timeliness. Non-VA providers lack access to VHA's detailed billing, authorization, and clinical documentation requirements, leading to increased workload for VHA and Non-VA staff, and inadvertent duplicate billing and payment. Lack of provider education increases the risk of erroneously billed claims, affecting claims backlogs as the Non-VA providers resubmit for unpaid services.
- **Complex Policies:** High risk of improper payments due to complex rules and Non-VA Care claims submission requirements causes confusion, inefficiencies, and increases errors. Complex rules and disparate processes result in inconsistencies in authorization and payment practices. Without common, standardized processes and procedures, claims clerks conduct claim assessments inconsistently across VAMCs, potentially leading to inaccurate payment. Unclear authorizations lead to confusion among Non-VA providers and potential risk of improper payment for services not authorized.

- **Staff Vacancies and Poor Retention:** High staff vacancy rates and poor retention contribute to delays and errors in claims payment.¹⁸ During the implementation of the Veterans Choice Act in October 2014, CBO leadership reported there were 295 vacant positions (out of 1,982 authorized positions) for Non-VA Care claims clerks, supervisor, and support positions, such as clinical staff and budget technicians.¹⁹ Since the implementation of the Veterans Choice Act, CBO has indicated some progress reducing the number of staff vacancies; however, during our site visit interviews, we found staffing retention and vacancy rates to be a significant and widespread challenge facing local Non-VA Care operations.²⁰ Vacancy rates and staffing shortages lead to higher overtime costs, inexperienced staff, and a constant focus on employee recruitment, training and retention, which negatively affect the timeliness and accuracy of claims payments.
- **Patient Centered Community Care (PC3) Challenges:** PC3, comprised of HealthNet and TriWest, is a recently implemented network that VHA uses to supplement access to Non-VA Care. PC3 experiences challenges due to inadequate provider enrollment and stringent clinical documentation requirements. According to the OIG, PC3 has not met the PC3 contract requirements for full implementation of the networks in six provider regions by April 2014 (OIG, 2015). Existing local VAMC contracts that frequently pay higher rates with less administrative burden further challenges PC3. Additionally, PC3 does not consistently return contractually required medical documentation in a timely manner. We note that the PC3 contract requirement to collect medical records for every claim prior to payment is burdensome in comparison to industry best practices.

5.2.2 Major Recommendations

The following recommendations are key actions and process improvements that VHA should take to address the significant issues existing with the Non-VA Care payment processes to enhance payment timeliness and accuracy, avoid penalties, and develop positive relationships with network providers. VHA must address the underlying issues and take action on these recommendations to ensure Veterans have the needed access to the Non-VA care network of providers.

- **Establish Single Set of Guidance:** Adopt a single set of practices and guidance for authorizing and paying Non-VA claims. Review and evaluate the existing authorization and claims processing procedures at high performing facilities and interview industry experts to determine best practices. Increase electronic claims submission rates by creating

¹⁸ CBO Purchased Care Operations Directorate indicated that they began tracking staff turnover rates; however, they only began tracking this data in October 2014, limiting our ability to draw comprehensive conclusions. In addition, CBO tracks and reports turnover data on a pay period basis.

¹⁹ Per CBOPC OPS FTEE by VISN.xlsx prepared by CBO Purchased Care Operations Directorate

²⁰ As of August 2015, there are currently 83 vacancies within Non-VA Care; however, over that same time, CBO transferred a number of positions to other departments, reducing the total number of authorized positions in Non-VA Care to 1,871. The CBO provided the updated number of staff vacancies and authorized positions but the data was not independently validated.

provider manuals, known in the industry as 837 companion guides, to give Non-VA Care providers the information needed to submit electronic claims successfully. Also, encourage, through contract provisions and preferential contacting approaches, Non-VA Care providers to submit electronic rather than paper claims. Standardize the Non-VA Care claims processing methods and train claims clerks accordingly.

- **Reduce Complexity:** Similar to VHA Revenue, Congress and VHA should undertake a complete review of the Veteran eligibility, service-connected, non-service connected and many benefits rules and categories and develop a single, comprehensive, easy-to-understand set of guidelines that align as much as possible to industry standards.
- **Establish Common Reimbursement Structure and Methodology:** Develop and implement a common reimbursement structure and process for Non-VA Providers that eliminates the multitude of individual and different contracts with providers and that simplifies the entire process. Revise contracts with HealthNet, TriWest, and other Non-VA providers to incorporate a common reimbursement methodology.
- **Establish Transparent Reporting of Interest:** Accountability at the facility level is necessary to ensure process improvements to payment processes to eliminate or reduce interest payments. Stronger coordination between Corporate Office and VAMC level management over interest penalties will provide the ability to analyze and identify root causes of interest penalties on an ongoing basis, and proactively develop corrective actions.

5.3 Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.

This finding relates to the information technology (IT) tools and applications that VHA uses to support the various processes involved with the VA Care revenue cycle and the Non-VA Care claims payments. We address VA Care and Non-VA Care processes and associated tools separately due to their magnitude and significant differences.

It is important to note for our technology review that VA established the Office of Information Technology (OIT), under the Chief Information Office (CIO) to centralize the development, delivery, operation, and management of IT capabilities across the Department. In the past, while VHA worked with OIT to prioritize IT needs, OIT ultimately set the funding priorities.²¹

Information technology, automation of manual processes and other applications and tools are essential in effectively and accurately processing and meeting the substantial requirements for revenue collection and claims payments. The current state of automation within VHA presents many opportunities for improvements.

²¹ Assessment H provides a more detailed discussion on the OI&T centralization.

The following sections summarize the root causes and major sub-findings that contribute to this overarching finding. Chapter 8, Information Technology, includes the detailed discussion, evidence, and data sources required for a more complete understanding.

5.3.1 Major Sub-Findings—Information Technology: VHA Revenue

- **Inadequate Technology:** Systems for revenue collection require significant manual intervention, causing errors and delays. VHA will not be able to make the needed improvement in their billing and collection processes without integrated, automated technology. Antiquated systems used to support revenue collection for third-party reimbursements and first-party (Veteran) co-payments require increased spot checks and manual intervention. For example, VHA executes the coding and billing functions on separate platforms inhibiting synchronization of information. The lack of system integration also prohibits sharing of information across clinical and revenue management systems. Additionally, VHA's clinical systems do not automate clinical documentation and coding functions as efficiently as private-sector systems.
- The systems require significant manual intervention and processing that creates an environment prone to human error and delays billing. For example, CPAC billing staff members manually review 100 percent of bills to third-party insurance (also referred to as claims), subsequent to automated edits. In the private sector, clerks manually review only 10 to 20 percent of claims, subsequent to automated edit and correction. In addition, manual processes are required to verify that Veteran care bills are compliant with the third-party insurance contracts.

5.3.2 Major Recommendations—Information Technology: VA Care Revenue

- **Fund and Implement an Integrated Patient Accounting System:** VHA should continue efforts they have initiated to begin planning for an integrated and automated billing system.²² VHA, in coordination with VA OIT, should prioritize funding and accelerate efforts to implement an integrated patient accounting system that supports synchronization of information, minimal work processes, and automated decision-making. VHA should prioritize the integration of tools (and functions) across patient intake, clinical administration, and billing systems. In particular, we recommend VHA to integrate medical records, coding, and billing systems under one login to facilitate expedited claims generation and payment. One integrated system will allow billers and coders to access the information they need from one site rather than multiple sites, reducing human error, and time needed to complete tasks. Once a new integrated solution is developed and put into place, VHA should reevaluate staffing levels to account for the change in workload and reallocate personnel accordingly.
- Evaluate technology that will allow Patient Intake staff to access patient's out-of-pocket responsibilities real time. Invest in technology that allows for generation of enhanced

²² Based on interview with the Deputy Director of Revenue Systems Management.

itemized statements for patients including information related to third-party payers billed, detail of charges (description, quantity, and amount), payments and adjustments, and contact information for billing and other questions. Evaluate a solution for calculating the optimum payment plan for each Veteran based on the patient's ability to pay and the organization's payment plan guidelines.

5.3.3 Major Sub-Findings—Information Technology: Non-VA Care Payments

- **Inadequate Technology:** Manual payment process for Non-VA Care providers negatively affects timeliness and accuracy. The high rate of manual intervention is in contrast to the private sector, where payer systems typically carry an edit status or disposition. An additional systems complication is that Non-VA Care claim processing system is not able to process all types of Non-VA Care claims. For example, VHA cannot process dental and contract nursing home claims through the current Non-VA Care claims processing system (FBCS). These claims require a much higher level of manual effort.
- **Missing Claims Status:** VHA lacks an online resource for Non-VA Care providers to check claims status. Modern workflow tools routinely provide a capability for online status; such as, checks of orders, payments, shipping. Most major payers provide claims status updates online, which is quickly becoming an industry standard that increases provider satisfaction. Providing online claim inquiry will also eliminate duplicate claims submitted by Non-VA Care providers with a subsequent reduction in manual claims processing.
- **Decentralized Claims Processing:** The Non-VA Care claims processing system is not centralized, leading to inconsistencies in claims processing across VAMCs. Consequently, there are discrepancies among deployed technical processes and local instances of the FBCS. These differences have also limited VHA's ability to create keystroke-level training and desk-level procedures, which affects both timeliness and accuracy.
- **High Staffing Levels:** The process to pay Non-VA providers requires higher staffing levels relative to other payers. VHA's Non-VA Care claims processing system is heavily reliant on manual processes when compared to health plans. Currently, the Non-VA Care claims processing system auto-adjudicates zero percent of claims compared to private-sector payer benchmark of 79 percent.

5.3.4 Major Recommendations—Information Technology: Non-VA Care Payments

- **Strategic Planning:** Develop and implement both a short-term and a long-term plan to reduce the degree of manual intervention in claims adjudication and other manual processes related to Non-VA Care business processes. Automation will lead to provider satisfaction and reduce the burden on the Non-VA Care claims staff, which will increase claims payment timeliness.
- **Claims Status:** Create a provider portal so that providers can routinely check the status of submitted claims, and a centralized call center with dedicated staff to answer Non-VA provider questions.

- **Funding:** VHA and CIO/OIT should work in close, coordinated partnership and within required regulation guidelines to address IT challenges for improving both collection and payment processes and, ultimately ensure funding to help secure the long-term viability of the Veterans’ health program. Short-term fixes do not do justice for VHA staff or the Veterans they serve.

5.4 Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.

The processes to effectively monitor and oversee collections and payments are essential to sustain process improvements across VHA. The findings and recommendations in this section address opportunities to benefit from stronger national reporting, leveraging private-sector benchmarks, more insightful decision support, common productivity standards, and management over timely payments. The findings also address program integrity tools, through which CBO is realizing results and should continue using to identify systemic issues. Chapter 9 includes the detailed discussion, evidence, and data sources required for a more complete understanding.

5.4.1 Major Sub-Findings—Oversight and Metrics: VHA Revenue

- **Lack of Insurance Capture Reporting:** VHA lacks standard national reporting of key performance metrics for timely insurance identification and verification across VHA, inhibiting visibility into insurance capture across VAMCs. Insufficient national reporting on Patient Intake key performance metrics hinders visibility into the Patient Intake functions of VAMCs and contributes to lack of accountability by all responsible parties.
- **Inconsistent Performance Measures:** Reporting in the current patient accounting system (VistA) is not comparable to private sector, inhibiting the identification of areas for improvement. For example, Days to Bill, GDRO, and contractual adjustments are all calculated and reported differently in the private sector.
- **Lack of Oversight of Regional Contracts:** Regional contracts with payers lack the necessary support from VHA’s Revenue Operations Payer Relations Office. Local CPAC Payer Relations staff manages VHA’s regional contracts with minimal oversight from the Revenue Operations Payer Relations Office. This arrangement limits the opportunity for local regional contracts to reap the benefits and negotiating strengths of the Revenue Operations Payer Relations Office. Without effective payer contracting and oversight in place at the regional level, mechanisms to ensure payment accuracy is diminished. Further, loss of revenue may occur, directly affecting the collection of amounts owed to VHA for care provided.

5.4.2 Major Recommendations—Oversight and Metrics: VHA Revenue

- **Elevate Reporting:** Evaluate the current reporting capabilities of the patient accounting system and perform a gap analysis with equitable private-sector reports. This would

further enhance VHA's ability to identify the root causes for process improvement areas and knowledge from which to develop and act on resolution plans. VHA should align performance measures to those used by industry, giving VHA leadership meaningful comparisons of performance to the private sector.

- **Perform Realignment:** CPAC Payer Relations staff should report to the Revenue Operations Payer Relations Office. This will allow VHA to optimize reimbursement rates leveraging economies of scale. A standardized approach should allow for flexibility at the CPAC/regional level, while addressing issues promptly with national advantage, particularly payer negotiations. Payer Relations staff should remain co-located at the CPAC to better understand regional influences and maintain a local presence.

5.4.3 Major Sub-Findings—Oversight and Metrics: Non-VA Care Payments

- **Lack of Productivity Standards:** As of April 1, 2015, VHA cannot establish effective productivity standards and monitor employee performance because its processes are not consistent across VAMCs and VISNs.²³ For example, at some VAMCs claims clerks work closely with the authorization personnel and are involved in care coordination, while others do not.
- **Inadequate Decision Support:** Current decision support capabilities are not sufficient to support oversight and management of Non-VA Care claims processing and payment. The analytical deficiencies across claims processing and payment prevent VHA from effectively assessing the performance and management of the processing system. Due to this deficiency, VHA is unable to analyze enterprise-wide denials.
- **Labor Intensive Oversight:** Proactive and retrospective processes are in place to find inaccurate payments, but some practices are manual. Reviews and audits to monitor improper payments are largely retrospective in nature; therefore, for any overpayments identified through these reviews and audits, VHA must invest time and money to recoup overpayments to Non-VA providers.
- **Lack of Oversight of Interest Penalties:** Currently, VHA's oversight of interest penalties is limited to VHA Corporate Office and not locally at VAMCs. As a result, VHA inconsistently communicates interest penalties down to the CBO staff at the VAMCs. Lack of accountability at the local level prevents needed improvements in payment timeliness.

5.4.4 Major Recommendations—Oversight and Metrics: Non-VA Care Payments

- **Establish Standardized Productivity Standards:** Establish standardized Non-VA Care productivity standards for staff across VAMCs and VISNs. VHA should employ these standards to project staffing needs and evaluate staff performance to assure sufficient staff

²³ Since the time of our review, the CBO indicates that they have made significant improvements to implement these standards. The timing of this information was out of the scope of our review; therefore, the Assessment I team could not validate this statement.

to support the claims processing process. As Non-VA Care continues to evolve, continually assessing VHA staffing levels is critical in leveraging human resources necessary to improve the accuracy and timeliness of claims processing.

- **Improve Review and Oversight:** Build upon and improve current pre- and post-payment review and oversight practices, so that VHA is using the most effective and highly automated tools and practices with emphasis on automated pre-payment edit techniques.
- **Establish Transparent Reporting of Interest:** Accountability at the facility level is necessary to ensure process improvements to payment processes to eliminate or reduce interest payments. Stronger coordination between VHA Corporate Office and VAMC level management over interest penalties will provide the ability to analyze and identify root causes of interest penalties on an ongoing basis, and proactively develop corrective actions.

5.5 Additional Considerations

While conducting research for this study, we gained many insights regarding VHA Revenue and Non-VA Care. We provide below some additional considerations for VHA's business processes.

5.5.1 Holistic, Long-term Planning

VHA should develop a long-term holistic plan for provision of and payment for health care services (180 days).

Rationale: The growth of Non-VA Care over the last decade has resulted in a combination of programs that, as evidenced by our report, do not have sufficient infrastructure to successfully perform the business functions today nor meet the demands of the future. The demand for Non-VA Care will be determined, in large part, by the decisions made regarding VA Care and, in turn, VA's capacity to meet demand for services. For example, decisions about VHA facilities and workforce will affect demand for Non-VA Care, as could changes in the demographics and clinical needs of Veterans. VHA should supplement the plan with the results of VHA's ongoing capacity and other ongoing studies. This will also allow VHA to evaluate whether areas that are suffering from under capacity are using PC3 more than other areas. Furthermore, Non-VA Care or other approaches to outsourcing could present opportunities for VHA to adopt best and emerging practices in health program administration, care management, preferred or tiered provider networks, provider payment and other areas.

To be successful, the long-term plan should account for the factors discussed above and allow for adoption of best practices from the private sector and other government sectors (e.g., the Medicare program, related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels, to reflect regional and local differences in provider supply, Veteran needs, and marketplace characteristics, among other factors.

VHA should establish formal governance model that allows CBO and VISN leadership to converge, aligning interests, and accountability (90 days).

Rationale: An organization structure that balances central management with local autonomy is vital to VA. In order to do so effectively, accountability and interests should align at the leadership level. Concerning business processes, the execution of core CBO functions is often dependent on coordination with VAMC and VISN actions. Under VA's current organization, since CBO and VISNs report separately to the VHA Office of the Under Secretary, VAMC priorities do not always align with CBO's. The significance of both VA and Non-VA Care requires an increased focus on business processes to sustain care for the Veteran population. Aligning both organizations under a single governance structure will converge interests and accountability resulting in the necessary cooperation and alignment to enable success.

5.5.2 Choice Act Implementation

VHA should standardize policies and procedures for execution of the Choice Act and communicate those policies and procedures to Veterans, VHA providers and staff and Non-VA providers (180 days).

Rationale: Our study was limited in scope to Non-VA Care claims payment timeliness and accuracy and interest penalties; however, examination of the claims processing protocols and operations revealed apparent opportunities to standardize the manner in which the Choice Act is implemented across VAMCs and VISNs and to improve VHA communications about Choice Act-related developments. Standardization will enable VHA staff members to communicate processes and benefits effectively to both patients and Non-VA providers. For the PC3 program, there appears to be tremendous confusion for both the providers of care (VA and Non-VA providers) as well as VHA staff, providers, and patients regarding authorization requirements, networks, out of pocket responsibilities, etc. VHA should determine outreach efforts that best optimize the message (e.g., newsletters, town hall meetings to help internal and external stakeholders understand the policies and processes related to PC3 and The Choice Act).

5.5.3 Non-VA Care Contracting and Oversight

VHA should identify opportunities to align payment and incentives among Non-VA Care programs and contracts and to strengthen the terms and oversight of those contracts, and VHA should centralize and inventory local contracts with Non-VA providers across all VAMCs (1 year).

Rationale: Our study was limited in scope to Non-VA Care claims payment timeliness and accuracy and interest penalties; however, examination of the claims processing protocols and operations revealed apparent opportunities for VHA to improve many aspects of its Non-VA Care contracting. Under the current model, VHA processes claims twice—once by the PC3 vendor and a second time by VHA to determine payment amounts. This is not reflective of typical Third Party Administrator arrangements and result in additional costs.

It appears that PC3 contracts and the oversight of those contracts, as well as VAMC contracts with providers, could strengthen through increased alignment, adoption of best practices in private sector and government health care contracting, and coordinated and rigorous management and oversight of those contracts. Private-sector and other government payers are increasingly adopting performance incentives, value-based purchasing, tiered or narrow

Assessment I (Business Processes)

networks, transparency, and data analytics to drive provider and member behavior change through outreach and education. We also noted inconsistencies regarding the number and types of contracts established at the local (VAMC) level.

With more insight into the breadth and depth of contracted services, the negotiated requisite fees, and the performance of the contracted entities, VHA will be better positioned to make more informed contracting decisions such as, but not limited to:

- Restructuring contracts if rates are not competitive with other payers and are affecting PC3 contractors' leverage in the marketplace
- Mandating that VAMCs use PC3 vendors for particular costly medical services
- Revisiting performance requirements for Non-VA providers.

6 Analysis of VHA Revenue

6.1 VHA Revenue—Introduction

Congressional appropriations fund the care and treatment provided to Veterans. Congress provided VHA with the authority to bill Veterans and health insurance companies for Veterans' non-service connected care to help defray the cost of delivering medical services.²⁴ VHA considers a Veteran's health care "billable" if the care provided is non-service connected and if the Veteran's third-party health insurance policy covers the treatment. The Omnibus Budget Reconciliation Act of 1990 established standard out of pocket co-payments for billable treatment.

Many Veterans qualify for free health care and/or prescriptions based on service-connected conditions, special eligibility factors, and specific services exempt from inpatient and outpatient co-payments (e.g., counseling). All remaining Veterans with private-sector insurance coverage pay co-payments to help offset the cost of care.²⁵ VHA's non-service connected co-payment amount is limited to a single charge per visit regardless of the number of health care providers seen in a single day. VHA bases the co-payment amount on the Veteran's income and highest-level clinical service received on the date of service.²⁶ Note, if the insurance company pays VHA an amount that exceeds the co-pay, VHA reimburses the co-pay amount back to the Veteran. VHA uses this process to incentivize Veterans to provide insurance information.²⁷

The Balanced Budget Act of 1997 stipulates that VHA must deposit all payments from health insurance companies and Veterans into the Medical Care Collections Fund (MCCF) to offset the cost of care funded through congressional appropriations. VHA considers services that are billable to the Veteran as "first party" (i.e., co-payments) and those that are billable to an insurance company as "third party." MCCF funds return to the VHA health care facility that provides the care for the Veteran. Table 6-1 outlines the first- and third-party collections and estimates for FY2011–FY2015.

²⁴ Note: The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), enacted into law in 1986 established means testing for Veterans seeking care for non-service-connected conditions.

²⁵ Note: Under the Choice Act, insured Veterans are explicitly required to provide insurance.

²⁶ U.S. Department of Veterans Affairs. (2015, June 5). Health Benefit Copays [VHA Benefit Information]. Retrieved from <http://www.va.gov/HEALTHBENEFITS/cost/copays.asp>

²⁷ Based on review of 38 CFR Part 17, RIN 2900-AP24. Expanded Access to Non-VA Care Through the Veterans Choice Program. November 5, 2014.

Table 6-1. Total First and Third-party Collections, FY2011-2015 (\$ in thousands)²⁸

	FY2011 Actual	FY2012 Actual	FY2013 Actual	FY2014 Actual	FY2015 Estimate ²⁹
First-party co-payments ³⁰	956,461	970,180	923,508	885,228	939,762
Third-party insurance Collections	1,754,875	1,770,911	1,940,014	2,169,932	2,424,677

6.1.1 VHA Revenue—History

VAMCs initially performed all revenue cycle functions, including billing and collections. While this approach achieved momentum in supplementing congressional appropriations, it lacked coordination and standardization, which hindered VHA’s ability to maximize revenue. Multiple OIG and GAO reports have documented performance issues, as discussed in the past findings and recommendations section of this report. In 2008, Public Law 110-387 passed, requiring VHA to consolidate business office operations so VHA patient accounting activities, billing and collections, are aligned with health care industry best practices. As a result, VHA opened the first Consolidated Patient Account Center (CPAC) in October 2009, as a pilot facility in Asheville, NC. Table 6-2 shows the growth in MCCF collections from fiscal year 2006 to 2012.

Table 6-2. Total MCCF Collections, FY2006-2012 (\$ in thousands)³¹

	FY2006	FY2007	FY2008	FY2009*	FY2010*	FY2011*	FY2012*
MCCF Collections –FYTD ³²	1,958,759	2,176,625	2,419,157	2,734,950	2,773,968	2,711,336	2,741,091

*In 2009, VHA first consolidated patient accounting functions at the Mid-Atlantic CPAC in Asheville, NC. Six remaining CPACs followed, with the final CPAC operationalizing on September 24, 2012. VHA placed the CPACs under the Central Business Office (CBO). Figure 6-1. CPAC & VISN Regional Alignment depicts the CPACs, dates operationalized, and associated regions.

²⁸ National Collections (2015). Fiscal Year 2011-2015 First and Third Party Collections. [POWER collections data]. Retrieved from CBO.

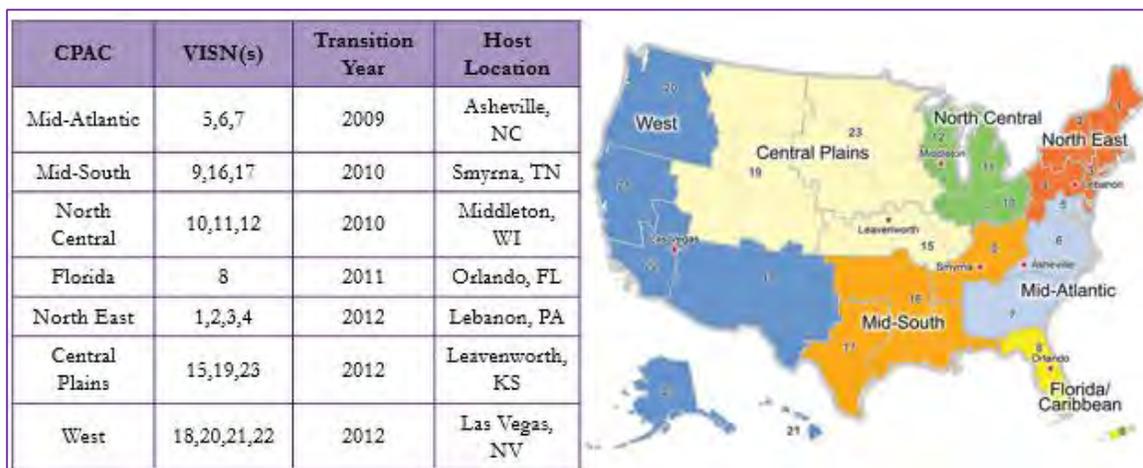
²⁹ Note: FY2015 estimates are based on data from October 2014- April 2015, annualized using the equation: ((Total Collections/7)*12).

³⁰ Note: First-party co-payment totals include co-payments for pharmacy, inpatient and outpatient care, and long-term care.

³¹ MCCF Collections (2015). FYTD 2006-2012 MCCF Collection Actual FYTD to Expected Results. [CBO MCCF collections data] Retrieved from CBO.

³² Note: This collection data contains both first and third party collections.

Figure 6-1. CPAC & VISN Regional Alignment



Source: Grant Thornton rendition based on CBO feedback. Note: VISNs 13 and 14 do not appear on this figure because they were combined into VISN 23.

Each VAMC is located in a VISN, and all VISNs are assigned to one of seven regional CPACs. CPAC staff members are located both at the regional CPAC and at each VAMC to improve coordination and communication between the two entities. Chapter 3 describes the roles of VISNs, VAMCs, and CPACs in revenue cycle operations in more detail.

This industry-modeled, CPAC implementation:

- Centralized and enhanced billing and collections activities across VHA, which maximized economies of scale, and provided continuity and standardization
- Consolidated traditional revenue program operations into regionalized centers, closely aligning VHA billing and collections activities with industry best practices
- Placed ownership of revenue cycle processes deemed to be patient-facing at the VAMC level (front end)
- Transferred billing and collection activities to the CPACs (back end).

6.1.2 VHA Revenue—Current State

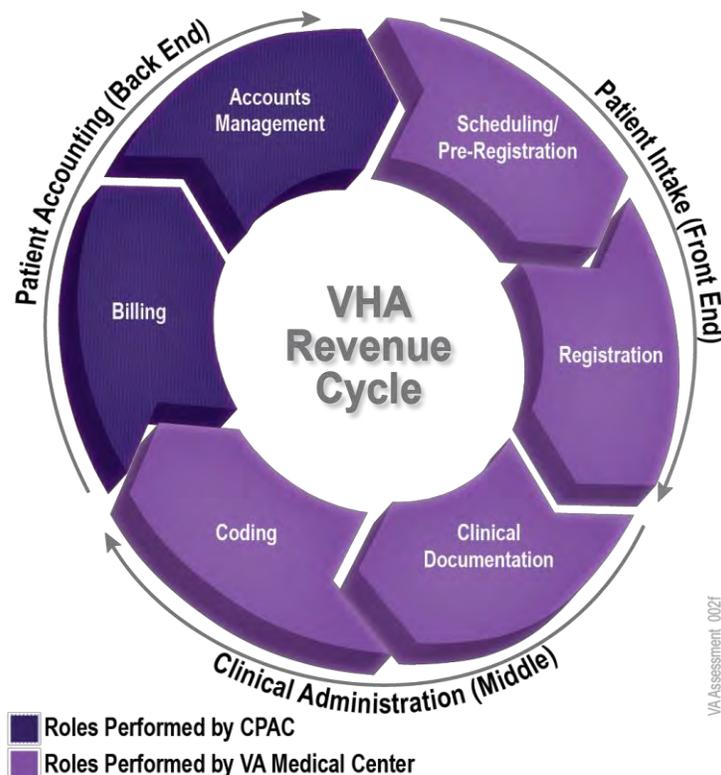
The transition to the CPAC structure drove standardization and coordination across Patient Accounting functions. Since the completion of the national CPAC implementation, national collections have increased by 14 percent to \$3.1 billion for calendar year 2014, while the related national billings increased by 17 percent.³³

Today, VAMCs continue to execute the “front end” and “middle” (Patient Intake and Clinical Administration) operations, and the CPACs, perform “back end” (billing and accounts management) operations. Together, these operations comprise VHA’s revenue cycle. Figure 6-2

³³ CBO. (2015). *Total Collections to Billings, Calendar Year 2012-2014*. Retrieved from POWER.

illustrates VHA's revenue cycle responsibilities and aligns the responsibilities to the CPAC or VAMC.

Figure 6-2. Process Areas and Key Components



Source: Grant Thornton's rendition of the VHA Revenue Cycle

- Patient Intake:** Patient Intake activities occur at the beginning of a Veteran's interaction with a VHA provider. These activities typically include scheduling, pre-registration, registration, point-of-service collections, insurance identification and verification, and financial counseling. At VHA, the Patient Intake functions reside at the VAMCs, referred to as Patient Administration Services (PAS), Hospital Administration Services (HAS), or Medical Administration Service (MAS)—the name varies depending on the VAMC visited. Currently, VAMCs are responsible for identifying insurance, while the CPAC is responsible for verifying insurance. The CPAC cannot verify insurance if it is not identified and communicated by the VAMC.
- Clinical Administration:** Clinical Administration activities occur after a VHA clinician has treated a Veteran. During this phase, the clinician completes all clinical documentation and signs off on the encounter. Subsequently, VHA coders review the encounter's clinical documentation, assign appropriate codes, and submit the validated and coded encounter to billing for submission to third-party payers. Clinical Administration functions reside at the VAMCs and are performed by both clinicians and coders (also referred to as Health Information Management Services [HIMS]).

- **Patient Accounting:** At VHA, CPACs oversee all Patient Accounting functions, which include billing, accounts receivable (AR) management, follow up, denials management, first-party follow up, cash applications and adjustments, regional payer relations, and customer service.

6.2 VHA Revenue Assessment Approach

6.2.1 Data Sources and Analysis

As described in the methodology of this report (Chapter 2), our approach comprised of information collection, analysis, interviews and process walkthroughs. We collected a variety of qualitative and quantitative data that directed our findings and recommendations. This data includes: (1) billing and collection performance data (2) coding turnaround time/backlog data, (3) clinical documentation latency data, and (4) a VAMC-wide data call for insurance identification and pre-registration data. Additional data sources include interviews with more than 63 VHA revenue staff members as well as several executive interviews with VHA leadership. Our data collection and analysis focused on assessing the key components of VHA’s revenue cycle. Table 6-3 outlines the key components, examined by our assessment, and the VHA functions that perform each component.

Table 6-3. Key Components of VHA Revenue Cycle

Process Area	Key Components	Performed By
Patient Intake	<ul style="list-style-type: none"> ▪ Scheduling/Preregistration/Registration <ul style="list-style-type: none"> ○ Insurance identification ○ Veteran eligibility ○ Demographics 	VAMC
Clinical Administration	<ul style="list-style-type: none"> ▪ Clinical Documentation <ul style="list-style-type: none"> ○ Timeliness and accuracy ○ Response to physician queries ▪ Coding <ul style="list-style-type: none"> ○ Receipt of clinical documentation ○ Coding all inpatient and billable outpatient encounters ○ Health Information Management Services (HIMS) 	VAMC

Assessment I (Business Processes)

Process Area	Key Components	Performed By
Patient Accounting	<ul style="list-style-type: none"> ▪ Insurance Verification ▪ Revenue Utilization Review ▪ Billing <ul style="list-style-type: none"> ○ First and third-party billing ○ Bill editor/edit checks ○ Submission to payer ▪ Accounts Management <ul style="list-style-type: none"> ○ Payment Posting ○ Cash Collection ○ Payer Relations (payment compliance) ○ Follow up and denials management 	CPAC

We used leading private-sector HFMA benchmarks and best commercial practices to evaluate VHA performance. For example, we used HFMA benchmarks to analyze VHA performance in denial management, pre-registration, and first party collections (HFMA, 2012). For VHA data/metrics that did not align to commercial metrics, we used VHA standards of performance for our analysis. For a summary of the data and benchmarking used for this assessment, refer to Appendix D.

6.2.2 Past Findings and Recommendations

A key part of our approach was the review of findings and recommendations outlined in prior assessment reports. Since 2002, VHA has received several assessments on insurance identification and third-party revenue collection performance. These assessments have identified several challenges, including difficulties with identifying patients with third-party insurance (OIG, 2012),³⁴ clinical documentation limitations (OIG, 2012),³⁵ and ineffective billing and accounts management processes (GAO, 2008). Our team outlined a sample of key findings from these assessments in Table 6-4. The assessments are included in the References provided in Appendix E. Note that these examples illustrate the type of factors identified in recent years, and are not intended to be a comprehensive listing.

³⁴ Department of Veterans Affairs Office of Inspector General. (2012). Audit of VHA’s Medical Care Collections Fund Billing of VA-Provided Care. Report No. 11-00333-254. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf>

³⁵ Ibid.

Table 6-4. Previous VHA Care Report Findings

Process Area	Cited Findings	2002	2005	2007	2008	2012
Patient Intake	Lack of timely third-party insurance identification	OIG				OIG
	Pre-registration functions are not being performed	OIG				
	Patients are not educated on the value of third-party insurance collection	OIG				OIG
	Limitations in insurance identification training for clinical administration staff	OIG				OIG
Clinical Administration	Clinical documentation practices are inconsistent	OIG			GAO	OIG
	Residents and attending physicians are not appropriately documenting encounters			OIG		
Patient Accounting	Failure to develop and use metrics to track timely and accurate billing performance		GAO		GAO	
	Accounts management follow-up processes are not following VHA standards	OIG	GAO		GAO	
	Non-billable encounters are not being reviewed to maximize billing opportunities				GAO	OIG

VHA’s revenue cycle functions have not received the same level of evaluation as other direct patient care areas of VHA, however, VHA has received feedback on methods to improve insurance identification and third-party collections. These past assessments have tended to provide broad compliance oriented recommendations. In contrast, our assessment tries to take an end-to-end view of the challenges in VHA’s revenue operations and identify recommendations that would specifically address each challenge.

In reviewing the recommendations presented in past reports, the majority focused on the following recommendations:

- Providing additional guidance on insurance identification to clinical administrative staff and implementing methods to monitor their compliance

- Promoting the importance of insurance identification to Veterans and staff by demonstrating how third-party collections benefit VHA’s ability to provide medical services to Veterans
- Improving clinical documentation practices to ensure appropriate coding and billing of encounters
- Ensuring adequate documentation of resident-provided care and timely submission of attending notes for appropriate billing
- Evaluating encounters determined to be non-billable to ensure that VHA maximizes billing opportunities for VHA-provided care
- Requiring the development and use of management reports on the accuracy and timeliness of billing performance
- Ensuring that AR staff members perform the first follow-up on unpaid claims within 30 days of the billing date and establishing procedures for monitoring compliance.

6.2.3 Revenue Operations Strategic Plan

We reviewed the CBO Revenue Operations Way Forward Strategic Plan (2014–2016) and noted a number of initiatives to maintain and improve upon collections exist in support of their strategic goals to:

1. Realize a “Best in Business” revenue program—increasing collections and achieving industry performance standards.
2. Streamline revenue operations and enhance supporting technology—reducing the Cost to Collect.

The initiatives associated with these goals pertinent to our findings and recommendations are:

Table 6-5. Key Intersections with Way Forward Strategic Plan

Initiative	Strategic Target
Implement a Customer Relationship Management system to track Veteran interactions and provide seamless customer service	FY 2015/Q1
Support the implementation of International Classification of Diseases version 10 (ICD-10) to ensure continuity of operations and minimize revenue loss during transition	FY 2015/Q1
Identify, support and promote opportunities to improve clinical documentation	FY 2015/Q4
Establish process improvement task forces and enhanced procedures for insurance identification, clinic setup and non-MCCF revenue functions	FY 2015/Q4
Maintain commitment to “Gold Standard” Quality Assurance and Internal Control Programs	FY 2016/Q4
Implement an automated billing system (ABS) that will result in a “touch-by-exception” environment	FY 2016/Q4

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Initiative	Strategic Target
Increase process automation through Enterprise Workflow Management Engine (EWME)	FY 2014/Q4
Deploy VistA Remote Access Management (VRAM) software to provide access to multiple VistA systems using a single set of credentials	FY 2014/Q2
Integrate HIM reporting with revenue workflow tools	FY 2014/Q4
Expand guidebooks to include standard operating procedures, detailed process models and quality standards for all revenue functions	FY 2014/Q3
Conduct outpatient consolidated coding feasibility study	FY 2016/Q4
Implement a comprehensive individual development program (IDP) that targets advancement against established competency models	FY 2015/Q2
Implement an interactive Knowledge Management System (KMS)—providing on-demand access to business information, training materials and operational support documents via self-service	FY 2016/Q4
Deploy a national revenue training and education delivery system to support virtual and self-paced instruction	FY 2014/Q2

The purpose of our assessment is to evaluate the status of current operations. We reviewed relevant plans and previous studies; however, an evaluation of the adequacy and status of these initiatives was beyond our scope. Please contact CBO or Revenue Operations for the status of completed, in process, or future initiatives listed in this plan.

6.3 VHA is Not Optimizing Revenue Due to Ineffective Veteran Insurance Identification, Clinical Documentation and Coding, and Culture Barriers.

6.3.1 Insurance Identification—Ineffective and Inconsistent VAMC Processes for Identification of Veteran Insurance Negatively Impacts Third-Party Collections.

Third-party collections involve the collection of amounts owed from insurance companies for care Veterans received from VHA. Key enablers of third-party collections include insurance capture and coverage determinations during Scheduling, Pre-registration, and/or Registration processes (collectively referred to as “Patient Intake”). Visibility into these key components allows for the assessment of performance in insurance identification and the associated collection of amounts due from third parties. This section addresses VHA’s performance across the key Patient Intake functions in identifying and verifying insurance.

6.3.1.1 Scheduling

The separate Veterans’ Choice Act Assessment E (Workflow – Scheduling) provides a complete, detailed analysis of the scheduling function at VHA. Our team reviewed the scheduling function

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

as it relates to insurance identification, verification, and pre-authorization. During our site visits, we conducted structured interviews with the PAS, HAS, or MAS departments that were responsible for scheduling patients' appointments. Additional assessment activities included viewing the systems and tools used by VA scheduling staff and reviewing VHA policies and guidebooks that were specific to scheduling.

Table 6-6. Scheduling

Scheduling Defined: Point of entry for non-emergency care is through the scheduling of an appointment (for both inpatient and outpatient services).
Impact: Effective scheduling allows for accurate and timely insurance identification, verification, and pre-authorization. Each of these components are key drivers to maximize third-party collections.
Industry Best Practices: Schedule all non-emergent patients in advance to ensure the timely and accurate collection of demographic and insurance information. Centralized and standardized scheduling processes and procedures enable insurance identification and eligibility verification, prior to scheduled services. By using online technology tools, VHA can further facilitate verification of coverage prior to service.
VHA Key Finding: 1. VHA lacks standard scheduling practices and the requirement to identify insurance at the time of scheduling, inhibiting timely insurance capture.

Finding 1

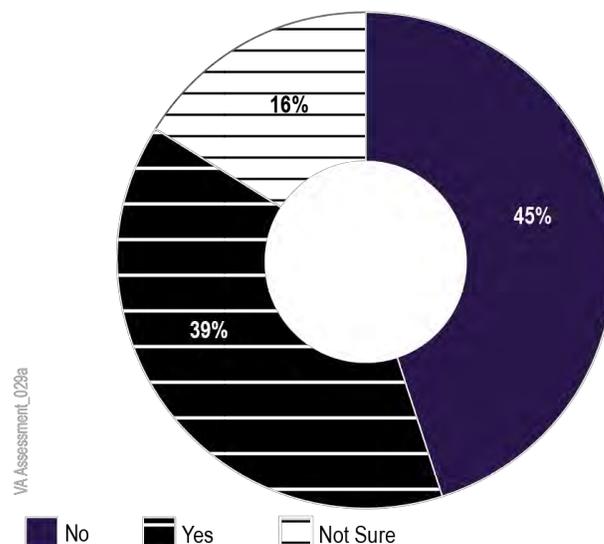
1. VHA lacks standard scheduling practices and the requirement to identify insurance at the time of scheduling, inhibiting timely insurance capture.

- The scheduling function is inconsistent and highly decentralized at each VAMC responsible for scheduling patients. Even within the same VAMC, scheduling practices are further decentralized and the practices vary across departments (i.e., Surgery versus Internal Medicine).
- We noted a lack of consistent insurance identification during the scheduling process, which is attributable to limited standard policies, procedures, and scripts.³⁶ Scripts should have a set of common questions for clerks to ask, including those related to the existence of third-party insurance coverage.

³⁶ Qualitative interviews at three VAMCs indicated that this was an issue.

- Assessment E surveyed the patient registration staff at VAMCs and the results were as follows:³⁷
 - As shown in Figure 6-3, out of 325 patient registration staff surveyed, 61.2 percent responded “No” or they were “Unsure” if insurance information was collected when patient visits are scheduled.³⁸

Figure 6-3. Patient Registration Staff Survey
Is insurance information collected at the time when patient visits are scheduled?



Source: Patient Registration Assessment E Survey Results

- Another 61.1 percent (approximately two-thirds of surveyed VAMCs) responded “No” or they were “Unsure” when asked if they were aware of policy, procedure or other guidance regarding insurance capture that guided the scheduling process.
- We also learned that not all VAMCs are consistently using the VistA scheduling packages.³⁹ This has a significant impact on revenue, as CPAC Revenue Utilization Revenue (RUR) nurses cannot obtain the necessary preauthorization for scheduled inpatient and outpatient services if patients are not scheduled using the VistA scheduling package.
- VHA’s scheduling function primarily focuses on obtaining demographic information and ensuring that the patient is enrolled for VHA benefits. Interviewees noted that when staff members do not capture insurance during scheduling, they cannot always bill third party insurance in a timely manner, or there can be delays to obtaining the necessary pre-authorization medical procedures (if at all).⁴⁰ Reimbursements may be lost as the CPAC is

³⁷ Assessment E Data Call. (2015). Survey of VAMC Patient Registration Staff. Unpublished raw data.

³⁸ Note: Survey of Patient Registration staff at VAMCs was a not a random or representative sample survey. Survey respondents were wholly self-selected.

³⁹ Qualitative interviews at one CPAC indicated that this was an issue and consistent with Assessment E.

⁴⁰ Qualitative interviews at three CPACs indicated that this was an issue.

unaware of the insurance company to bill, missing a timely billing statute when staff members identify the insurance late, or not obtaining required pre-authorization for services.

Recommendations

- **CBO/VAMC Task Force:** Update VHA Directives to require the identification of third-party payer coverage at the point of scheduling. Specifically, when schedulers establish or confirm appointments with the patient. Develop detailed scripts for VAMC schedulers to follow. These scripts will also be valuable for use in training sessions for Patient Intake staff.
- **VHA/VAMC:** Add insurance identification to scheduling staff performance plans.
- **CBO/CPACs:** Develop and implement a reminder tool/feature to give the scheduler a notice to ask for insurance information.
- **VAMC:** Verify all identified insurance using the electronic Insurance Verification (eIV) tool prior to the patient's appointment date. Coordinate with insurance verification teams at the CPACs to resolve discrepancies.
- **VHA/VAMC:** Develop and enforce same requirements for insurance identification and verification for non-scheduled patient walk-ins and patients arriving in the Emergency Department. This should occur as early as is practical for the situation (i.e., before, during, or immediately after the encounter, if possible), without unnecessarily interfering with the provision of care.
- **VAMC:** For recurring patient care (i.e., therapy patients, chemotherapy patients, etc.), re-verify (using the eIV tool) the Veteran's insurance every 30 days. Patient Intake staff should confirm insurance has not changed each time a Veteran checks in.

6.3.1.2 Pre-Registration and Registration

We assessed pre-registration and registration activities through a review of VAMC policies and procedures, VHA directives, structured interviews, and viewing tools used during patient check-in with staff from PAS, HAS or MAS (Patient Intake staff) and the CPAC (insurance verification).

Table 6-7. Pre-registration and Registration

Pre-registration and Registration Defined:

Pre-registration of scheduled patients is the second contact, where the patient provides insurance and demographics information. Prior to the patient's appointment, insurance information is verified and any necessary pre-authorizations are obtained.

Registration activities follow when the patient checks-in for their scheduled appointment. At this time, staff verify insurance information and demographics if the patient was not pre-registered or presents in the Emergency Department.

Impact:

Effective pre-registration allows for accurate and timely insurance verification and pre-authorizations, which increases cash collections and net revenue and reduces third-party denials.

Industry Best Practices:

All patients are pre-registered one to three days in advance of their scheduled appointment. Staff verify insurance benefits and pre-authorizations 72 hours prior to the patient's appointment using online technology tools. Registration should occur during appointment check-in to verify the patient's insurance and demographics information if they were not pre-registered.

VHA Key Findings:

1. Limited and ineffective pre-registration processes before the date of service across VAMCs, resulting in potential inaccuracies and timeliness issues for capturing demographic and insurance information.
2. Training on Patient Intake procedures vary across VAMCs, and within VAMCs, inhibiting timely insurance identification.
3. VHA relies on costly back-end processes and outside contractors to identify insurance

Finding 1**1. Limited and ineffective pre-registration processes before the date of service across VAMCs, resulting in potential inaccuracies and timeliness issues for capturing demographic and insurance information.**

- We noted a lack of national standardized processes related to pre-registration and the capturing of demographic and insurance information in Patient Intake.⁴¹ These activities are essential to insurance capture, in addition to obtaining pre-authorization from the insurance carrier prior to date of service, as is typically required. For scheduled patients with insurance on file, CPAC RUR nurses (located at VAMCs) will obtain authorization for episodes of care per insurance policy requirements to prevent payment denials. CPAC RUR staff cannot effectively obtain timely authorizations if VAMC's do not consistently pre-register the Veteran (prior to date of service).
- A VHA Pre-Registration Directive issued in February of 2007 mandated the use of pre-registration processes and systems to "achieve maximum collection potential." However, the directive expired on February 28, 2012.⁴² Based on interviews, we understand that some VAMCs implemented the 2007 Pre-Registration Directive to varying degrees of success. Our research revealed that a Patient Information Collection Management directive was issued on January 2011, which rescinded the 2007 Pre-Registration Directive

⁴¹ Qualitative interviews at four VAMCs indicated that this was an issue.

⁴² VHA Directive 2007-007 (February 2007). Pre-Registration Directive.

and provided pre-registration policy and procedures to VAMCs.⁴³ It appears based on discussions with VAMC staff; they are unaware of this updated directive or do not find it specific enough to drive processes.

- VHA does not calculate standard pre-registration rates consistently across VAMCs.⁴⁴ HFMA's best practice pre-registration rate is defined as the number of patient encounter's pre-registered (demographic and insurance information obtained and verified) divided by the number of scheduled patient encounters. The HFMA pre-registration rate is greater than or equal to 98 percent (HFMA, 2012)
- Since 'pre-registration rates are not available nationally, we requested and obtained this information as part of a national VAMC data call.⁴⁵ We learned that certain VAMCs calculate the pre-registration rate using the collection of information at check-in (not in advance of check-in). For this reason, we are not able to compare VHA's pre-registration rate with the industry benchmark.

Recommendations

- **VAMC:** Implement and enforce a standard pre-registration policy and process for all VAMCs to follow. The process should be coordinated between the scheduling functions at VAMCs and the insurance verification teams at the CPACs to ensure the identification and verification of insurance and demographic information.
- **VAMC:** Establish and enforce a national pre-registration rate as a standard key performance metric. Report the metric nationally and hold Patient Intake staff and VAMC leadership accountable for achieving it. Standard performance metrics must be aligned across VISNs, VAMCs, and CPACs and support an overarching metric of total collections. We understand that each CPAC has collections goals communicated to the respective VAMC leadership. Performance against collection goals should be communicated to both VAMC and CPAC staff, and aligned to individual performance. This is particularly important for Patient Intake staff to understand to improve performance in this area.

Finding 2

2. Training on Patient Intake procedures vary across VAMCs, and within VAMCs, inhibiting timely insurance identification.

- Interviews with VAMC staff revealed a shortage of national training on standard Patient Intake policies and procedures.⁴⁶ This lack of standard training has created variability in

⁴³VHA Directive 2011-003 (January 2011). Patient Information Collection Management Processes (PICM).

⁴⁴Qualitative interviews with two VAMCs indicated that this was an issue.

⁴⁵Source: For calendar year 2014, a pre-registration rate was obtained via a VAMC-wide data call. 123 VAMCs responded and provided data on the "Number of Unique Outpatients Pre-Registered" and the "Total Number of Unique Patients Treated During Scheduled Visit." We analyzed this VAMC data at the CPAC level to obtain an average pre-registration rate for calendar year 2014.

⁴⁶Qualitative interviews at four VAMCs indicated that this was an issue.

the methods Patient Intake clerks use to obtain demographic and third party insurance information.

- While Patient Intake staff at VAMCs complete training sessions to learn about updates to systems and policies, this training is not standardized and differs in content and complexity across VAMCs. For example, some VAMCs reported that Patient Intake staff were required to attend detailed training sessions led by PAS, HAS, or MAS leadership, while other VAMCs reported that training for Patient Intake is primarily focused on shadowing more experienced employees.

Recommendations

- **VAMC and CPAC:** Develop a formal training program managed by Patient Intake and Revenue Operations leadership. As part of this training program, Patient Intake staff should complete standard, recurring training sessions to learn about updates to systems and policies. This recommendation includes the following:
 - Create a national training program for the Patient Intake function and provide updated national policy and procedure guidebooks for all Patient Intake staff.
 - Develop detailed scripts to accompany standard policies and procedures for use during training sessions.
 - Require that new hires complete a comprehensive training program that includes insurance identification training, point of service collection training, financial counseling training, computer and systems training, and on-the-job training.

Finding 3

3. VHA relies on costly back-end processes and outside contractors.

- VHA relies on a contracted vendor to perform insurance identification and verification for missing insurance at a cost of \$14.75 for each billable policy identified and verified as in effect for the applicable date of service. This service resulted in identifying 254,672 billable insurance policies for calendar year 2014 at a cost of \$3.7 million to VHA.⁴⁷ Collections associated with these activities was not readily available. The vendor finds the patient's billable insurance and uploads it to VistA on the first day of every month.
- The reliance on back-end (CPAC) insurance verification, coupled with insufficient insurance identification and verification processes in Patient Intake, creates situations where insurance verification is being performed post the visit and too late, payers are not being billed, and payments are reduced or denied.

⁴⁷CBO (2015). *HMS Monthly Uploads Costs by CPAC, CY2014*. Data was received by CPAC (and associated VAMC) and included month/year, total billable policies, and invoice amount. National totals for Calendar year 2014 total were calculated by adding totals across all CPACs.

Recommendations

- **CBO:** Conduct cost benefit analysis for use of contracted vendor for insurance identification and verification compared to an in-house solution.
- **CBO:** Continue current efforts to upgrade and further develop the eIV tool that allows for insurance verification prior to the date of service. Doing so generates additional benefits not only for meeting precertification requirements, but also by eliminating third-party contractor service costs for missing insurance capture.
- **VAMC:** Standardize and enforce use of eIV tool for all non-service connected treatment in Patient Intake.

6.3.2 Coding and Clinical Documentation—Delays in VAMC Clinical Documentation and Outpatient Coding Backlog Prevent Timely Collections.

Clinical documentation and coding, categorized as “Clinical Administration” occur subsequent to Registration. After treating a patient, the clinician completes all clinical documentation and signs off on the encounter. Coders review the clinical documentation, assign appropriate codes, and submit the validated and coded encounter to billing for submission to third-party payers. To make sound coding decisions, leading practices are for coders to be certified.⁴⁸ Clinicians and coders should receive ongoing training to promote accurate and timely clinical documentation and coding as well as training on any major systems or coding changes. More details regarding VHA’s clinical documentation and coding processes for inpatient care are located in the Assessment F (Clinical Workflow) Report.

For the purposes of our assessment, we reviewed clinical documentation and coding processes for billable inpatient and outpatient encounters. We did not conduct an independent audit of the appropriateness of coding assignments and documented diagnoses and services. We examined industry leading practices in clinician and coder coordination and training, as well as, the tools and systems used to support correct code assignment.

Table 6-8. Clinical Administration

Clinical Administration Defined:

After providing medical services, a clinician completes and signs clinical documentation, indicating that the patient encounter is “closed.” Coding staff review and validate the completeness and accuracy of the encounter’s clinical documentation and assign requisite codes related to the patient diagnosis and procedures performed.

Impact:

Clinical documentation and coding is essential to the accurate assignment of clinical and billing codes enabling accurate third-party reimbursement.

⁴⁸Note: The American Health Information Management Association (AHIMA) is one of the major coding credentialing entity. Certified Coding Specialist (CCS). <http://www.ahima.org/certification/CCS>.

Industry Best Practices:

Clinicians typically complete clinical documentation within 24 hours. Clinicians should enter charges, assign codes, and close encounters in less than four days for inpatient encounters and six days for outpatient encounters. Clinicians should then submit coded patient accounts to billing so that claims are ready to submit to third-party payers.⁴⁹

VHA Key Findings:

1. Delays in clinical documentation turnaround time are inhibiting timely coding, billing and third-party revenue collection.
2. VHA is not consistently implementing and enforcing the national initiative around improving clinical documentation practices.
3. VHA is unable to code outpatient encounters promptly, resulting in outpatient coding backlog across VHA and preventing accelerated billing and collections.

Finding 1

1. Delays in clinical documentation turnaround time are inhibiting timely coding, billing, and third-party collections.

- Three factors contributing to this finding are (1) clinicians are not completing clinical notes and closing patient files on time, (2) clinical documentation issues are requiring significant coder follow-up, and (3) residents are not getting their attending physicians to cosign their encounters. Interviews with VAMC leadership indicated that there was a lack of clinician accountability for completing their clinical notes and patient files within VHA's targets and standards.⁵⁰
- Figure 6-4 outlines VHA's documentation and coding processes for all billable encounters. VHA coders review and code all billable and non-billable inpatient admissions and inpatient surgeries as well as all billable inpatient professional services.⁵¹ For billable outpatient encounters, VHA coders validate the accuracy of the clinician assigned code(s) by reviewing the encounter's clinical documentation. If the clinician's code(s) do not match the encounter's documentation, then VHA coders will adjust per the documentation. CPAC staff assigns patient encounters flagged as being billable to third-party insurance to VAMC coders for coding. When staff identifies billable insurance after the patient's encounter, the encounter assigns to the coder as a "new insurance late check-out" and is coded and sent to the CPAC for billing.

⁴⁹Per Grant Thornton industry subject matter expertise.

⁵⁰Qualitative interviews at four VAMCs indicated that this was an issue.

⁵¹Discussion with HIM leadership.

Figure 6-4. VHA’s Documentation and Coding Process Map for Billable Encounters



Source: Grant Thornton’s rendition of the VHA Documentation and Coding processes.

- VHA clinical documentation targets are for clinicians to complete patient a history and physical note within 24 hours of admission and to sign and close the patient’s medical record within seven days of discharge or outpatient visit.⁵² In the private sector, leading practices include clinicians completing clinical documentation within 24 hours, entering charges and codes, and closing the encounter in less than four days for inpatient encounters and six days for outpatient encounters.
- Table 6-9 summarizes clinical documentation delays from November 2014 to March 2015 for all billable outpatient encounters. The data revealed a delay in approximately 13 percent of billable outpatient encounters due to issues with clinical documentation (i.e., missing documentation, documentation with errors, or open outpatient encounters). This data supports interview findings.⁵³
- Interviewees consistently reported challenges with clinical documentation, specifically that clinicians were late in closing out their encounters and were submitting missing or incomplete documentation.⁵⁴ One site noted that many clinicians work part time at VAMCs, which significantly delays documentation turnaround when clinicians do not have remote access capacity to complete patient files or to answer coder’s questions.⁵⁵ Table 6-9 shows documentation latency percentages for outpatient encounters.

Table 6-9. Clinical Documentation Latency⁵⁶

Clinical Documentation Latency as % of Insured Outpatient Encounters (November 2014 – March 2015) is Impacting Collections						
	Nov '14 (%)	Dec '14 (%)	Jan '15 (%)	Feb '15 (%)	Mar '15 (%)	5 Month Avg*
Outpatient Encounters Requiring Clinical Action (Not Including Closing Out)	3.79%	3.78%	4.55%	5.06%	4.41%	4.32%

⁵²Note: Per VHA Directive 2011-025, workload closeout for all monthly updates to VHA corporate patient data files must be accepted by AITC no later than 7 days from the date of the Patient Treatment File (PTF) discharge and the inpatient or outpatient encounter.

⁵³Qualitative interviews at four VAMCs indicated that this was an issue.

⁵⁴Qualitative interviews at four VAMCs indicated that this was an issue.

⁵⁵Qualitative interviews at one VAMC indicated that this was an issue.

⁵⁶CBO. (2015). *Clinical Documentation Latency in Insured Outpatient Encounters, November 2014-March 2015*. Unpublished raw data.

Clinical Documentation Latency as % of Insured Outpatient Encounters (November 2014 – March 2015) is Impacting Collections						
	Nov '14 (%)	Dec '14 (%)	Jan '15 (%)	Feb '15 (%)	Mar '15 (%)	5 Month Avg*
Outpatient Encounters with Documentation Errors *(Not Including Closing Out)	5.40%	2.79%	3.25%	3.78	2.74%	3.59%
Outpatient Encounters Not Closed Out in 7 Days	5.94%	6.09%	5.34%	5.19%	4.04%	5.32%
Total Billable Outpatient Documentation Latency	15.13%	12.66%	13.14%	14.03%	11.19%	13.23%

Source: CBO. (2015). Clinical Documentation Latency in Insured Outpatient Encounters, November 2014-March 2015. Data and percentages were obtained from CBO. Five-month average was calculate by averaging November-March.

- When CPAC staff members submit late and incomplete encounters, this requires coders to spend significant time following up with clinicians to finalize an encounter’s documentation. For example, coders review physician query reports to identify encounters requiring clinician action (e.g., coder questions, documentation with errors). These activities delay coding turnaround time and the submission of coded encounters for billing to third-party payers.
- HIMS tracks inpatient and outpatient coding turnaround time. In reviewing the national HIMS inpatient metrics for calendar year 2014, VHA is performing above standard and in line with leading practices by coding billable and non-billable inpatient encounters within four days, ahead of VHA’s seven-day standard.⁵⁷
- However, VHA is performing approximately nine days below its own standard for the HIMS outpatient turnaround time metric for Calendar Year 2014. VHA is completing the turnaround time for outpatient encounters within an average of approximately 23 days as compared to the 14-day VHA target.⁵⁸ Since VHA coders are only reviewing and coding billable outpatient encounters while industry standard is to bill all encounters, this turnaround time delay and failure to meet national HIMS targets is notable. Interviewees at all visited VAMCs noted the timeliness of receiving clinical documentation as a root cause of the turnaround time delay.⁵⁹ VHA understands the importance of timely coding and the impact on the revenue cycle. The

Inpatient Coding: VAMC coders are consistently outperforming VHA standards for inpatient coding turnaround time by an average three days.

⁵⁷HIMS. (2015) *Calendar Year 2014 Inpatient Coding Turnaround Time*. Monthly VHA averages were received from HIMS and a national VHA average was calculated for calendar year 2014 based on the monthly VHA average.

⁵⁸HIMS. (2015). *Calendar Year 2014 Outpatient Coding Turnaround Time*. Monthly VHA averages were received from HIMS and a national VHA average was calculated for calendar year 2014 based on the monthly VHA average.

⁵⁹Qualitative interviews at four VAMCs indicated that this was an issue.

CBO Strategic Plan identified that VHA will conduct an outpatient consolidated coding feasibility study in Q4 of FY 2016.⁶⁰ The study will include the development of a work group to focus on current coding processes, workforce, costs, governance, and organizational alignment.

- During site visits to two of four visited VAMCs, interviewees reported challenges with resident physicians appropriately documenting encounters and getting their attending physicians to provide the required counter signatures. Interviewees reported that it was common for residents to treat patients and complete their rotation without ensuring the completion of a patient's treatment file or counter signing by an attending physician. VHA's internal policies and agreements with third-party payers state that they cannot bill a third party without an attending physician cosigning an encounter's documentation for resident-provided care. The 2007 OIG Report identified challenges with enforcing resident documentation compliance and third-party revenue losses (OIG, 2007). OIG recommended that VAMCs ensure resident and attending clinician compliance with the existing VHA Handbook for Resident Supervision.⁶¹
- VAMC personnel we interviewed during a site visit noted success with including incentives for clinical documentation performance in clinician's performance pay agreements.⁶²
- The issues in clinical documentation and coding illustrate that the mechanisms to ensure the accuracy of third party collections is inadequate.

Recommendations

- **VAMC Leadership:** Enforce existing national targets for clinicians to complete notes within 24 hours of admission and to sign and close the patient's medical record within seven days of discharge or outpatient visit. VHA should apply and enforce these requirements for all clinicians, full time and part time, as well as residents and their attending physicians and include them in performance plans.
- **VAMC Leadership:** Use performance pay agreements to assist with enforcing clinician compliance. Tie turnaround time compliance with performance ratings for VISN and VAMC Directors and Medical Directors. Inconsistent provider compliance with clinical documentation requirements could be resolved with appropriate penalties, such as reduced performance pay. Investigate increasing the weight placed on administrative elements in clinician's performance pay agreements, such as clinical documentation timeliness and accuracy.
- **VAMC:** Provide standard clinical documentation training to all clinicians. A CDI specialist should deliver this training and highlight the importance of clinical documentation in accurate and timely coding.

⁶⁰CBO. The Way Forward (February 2014). Revenue Operations Strategic Plan. February 2014. Pg 52.

⁶¹VHA Handbook 1400.01. Resident Supervision. Page 1-31.

⁶²Qualitative interviews at one VAMC indicated that this was a successful approach to address clinical documentation challenges.

- **VAMC:** Provide clinicians with remote access to VHA email/systems so that they can make updates to clinical documentation and respond to coder queries when offsite.

Finding 2

2. VHA is not consistently implementing and enforcing the national initiative around improving clinical documentation practices.

- VHA coders are spending excessive time querying clinicians to make corrections or updates to their clinical documentation, rather than providing corrective training. Some VAMCs use CDI programs to address challenges in clinician's documentation (Advisory Board, 2014). Dedicated CDI specialists are staff members that implement CDI programs, review patient charts, and train clinicians to improve their documentation practices.⁶³ VHA HIMS is providing national level guidance to VAMCs implementing CDI programs.⁶⁴ However, despite the availability of guidance, CDI programs are not mandated and only 46 percent of VAMCs reported having a CDI program.⁶⁵
- The inconsistent use of CDI programs and lack of national initiative around improving VHA documentation may be a contributor to the number of controllable medical necessity denials initially received. During calendar year 2014, there was \$14.2 million dollars of medical necessity denials initially received (or 1.3 percent of all denials initially received).⁶⁶ The submission of timely and accurate clinical documentation is required to bill an encounter and without an enforced national initiative around improving clinical documentation practices, VHA risks the collection of amounts owed from third parties.
- Lack of standardized clinical documentation practices poses a risk for VHA's ICD-10 readiness. The nationally mandated change in coding requirements from ICD-9 to ICD-10 is significant. It requires both clinicians and HIMS to adjust the way encounters are documented and coded, which will result in revenue that is more accurate. In October 2015, all providers will be required to be compliant with the new coding guidelines as mandated by CMS.⁶⁷ If clinicians do not document per new specificity guidelines, the appropriate code cannot be applied which will result in lost revenue from third-party payers. During site visits, we learned that there are national level ICD-10 preparation activities occurring and that VHA coders have started dual coding in ICD-10. In the private sector, leading ICD-10 preparation activities have included using CDI programs to train and educate coders and clinicians, streamlining ICD-10 communications, and optimizing the use of available clinical documentation and coding tools. HFMA has estimated that providers could see a 100-200 percent increase in denials and a 20-40 percent increase in

⁶³Note: CDI specialist role is focused on promoting clinical documentation improvement through ongoing measurement and provider education. Specialists will review medical records for incomplete or conflicting information and provide follow-up training. Previous coders or nurses with coding knowledge often fill these positions.

⁶⁴CBO. *The Way Forward* (2014). Revenue Operations Strategic Plan. pg 35 & VHA CDI Program Guide

⁶⁵HIMS (2014). *VAMC CDI Program Adoption Data*. Received this percentage from VHA HIMS.

⁶⁶CBO. (2015). *Total Initial Denials Received, CY2014*. [Data file and code book]. Retrieved from POWER.

⁶⁷45 CFR Part 162.

days in AR concurrent with ICD-10 implementation (HFMA, 2013). VHA's denials will likely increase significantly after ICD-10 implementation, which may negatively affect MCCF collections.

Recommendations

- **VAMC/HIMS Leadership:** Standardize the CDI program and mandate use across all VAMCs. VHA should provide designated CDI specialist funding to VAMCs to promote use of this essential role. These actions would improve the quality of clinical documentation, meet industry standards, and increase VHA's ability to collect appropriate third-party reimbursement. A standardized CDI role will also allow VAMCs to manage their controllable medical necessity denials and to provide corrective training to clinicians to improve their documentation.
- **VAMC/HIMS Leadership:** Perform tests of readiness using a national steering committee to ensure that VHA mitigates risk ICD-10 implementation. We understand VHA has taken steps to ensure ICD-10 technology and training is available to staff members. VAMCs should continue their local preparation activities and use a CDI program to train clinicians on ICD-10's more stringent clinical documentation requirements.

Finding 3

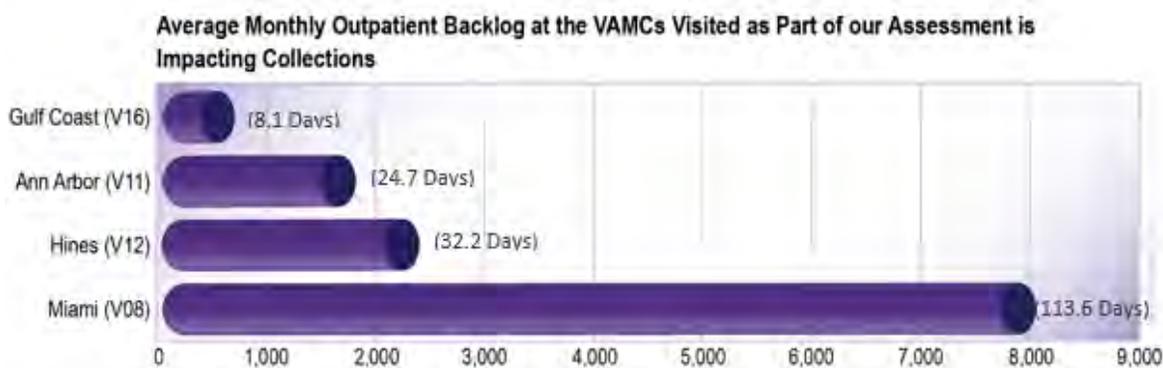
3. VHA is unable to code outpatient encounters promptly, resulting in outpatient coding backlog across VHA and preventing accelerated billing and collections.

- We identified an outpatient coding backlog at all VAMC site visits, which is significant considering that VHA coders only validate the accuracy of clinician assigned code(s) and apply correct codes as necessary for *billable* outpatient encounters, while the private sector codes and validates every patient encounter.⁶⁸ Figure 6-5 depicts the average monthly outpatient backlog at each visited VAMC for calendar year 2014, as reported by HIMS.⁶⁹ We estimated the average days' worth of backlog using the daily coder productivity standard of 70 outpatient records per coder found in VHA Directive 1907.03 (2012). In reviewing backlog data, we found that VAMCs are keeping up with their inpatient coding volume but have significant outpatient coding backlogs.

⁶⁸Note: The assessment requested national level backlog data. However, this data was not readily available and backlog data from each visited VAMC for calendar year 2014 was used instead.

⁶⁹Note: Interviews with Miami HIMS and Compliance staff revealed a significant outpatient backlog during part of Calendar Year 2014 due to high turnover among coding staff. The backlog was resolved with contracted coders and new coders have since been hired.

Figure 6-5. CY 2014 Average Monthly Outpatient Coding Backlog^{70,71}



Source: HIMS (2015). Calendar Year 2014 Outpatient Coding Backlog at Miami, Ann Arbor, Biloxi, and Hines. VSSC data. The HIMS backlog data contained monthly totals for calendar year 2014 that was separated by VAMC site. A twelve-month average was calculated by the assessment and excluded months where backlog data was not reported by the site.

Note: Interviews with Miami HIMS and Compliance staff revealed a significant outpatient backlog during part of Calendar Year 2014 due to high turnover among coding staff. The backlog was resolved with contracted coders and new coders have since been hired.

- To reduce their outpatient backlog, VAMCs often resort to using coding contractors.^{72,73} We found three factors contributing VHA's outpatient coding backlog: (1) There is a national shortage of certified coders, (2) VHA coders are responsible for more administrative duties than private-sector coders, and (3) VHA coder training is insufficient.
- There is currently a national shortage of certified coders and VHA struggles to compete with their private-sector peers to attract and retain high performing coders (Heubusch, 2008). VHA's 2015 Workforce Report identified an increase in the loss rate for coders (identified as Medical Records Technicians) from 6.8 percent in FY 2012 to 8.5 percent in FY 2013.⁷⁴ Interviews identified high turnover among existing coding staff and VHA's Workforce Report reported an increase in quit rates among coders from 2.6 percent in FY 2009 to 3.4 percent in FY 2014.⁷⁵ VHA's clinical coding procedures do not require the

⁷⁰HIMS (2015). *Calendar Year 2014 Outpatient Coding Backlog at Miami, Ann Arbor, Biloxi, and Hines*. VSSC raw data.

⁷¹Note: Interviews with Miami HIMS and Compliance staff revealed a significant outpatient backlog during part of Calendar Year 2014 due to high turnover among coding staff. The backlog was resolved with contracted coders and new coders have since been hired.

⁷²Qualitative interviews at two VAMCs and one CPAC indicated this.

⁷³Note: The average hourly rate for an outsourced coder is \$16.15.
http://www.payscale.com/research/US/Job=Medical_Coder/Hourly_Rate

⁷⁴VHA Workforce Management & Consulting Office. *VHA Workforce Planning Report 2015*. Page 59-60.

⁷⁵VHA Workforce Management & Consulting Office. *VHA Workforce Planning Report 2015*. Page 59-60.

hiring of credentialed coders, which departs from private sector leading practices.⁷⁶ Non-certified coders require additional training and supervision and may present an ongoing risk of compliance to VHA with the implementation of ICD-10. Qualitative interviews also revealed that VHA loses top coding candidates to the private sector because of slow hiring processes, increased responsibilities at VA, and a lack of competitive compensation.

- We also noted that VHA requires coders to perform administrative activities not required of private-sector coders. For example, since VHA providers do not routinely check Vista email, coders are forced to use various time consuming methods (phone calls, drop-ins, notes on charts) to obtain responses to documentation requests. Since coders are already coding much more than their private-sector counterparts (due to VHA's antiquated charge master system as explained in Section 8), VHA coders' additional administrative duties are significant and prevent them from working outpatient-coding backlogs.⁷⁷ Interviews revealed that coders are required to review open encounters and to follow up with clinicians to clarify or update their documentation (e.g., to identify or correct diagnosis and treatment information).⁷⁸ Coders are often responsible for providing ad hoc training to clinicians when they identify errors or inconsistencies in their documentation practices.
- VHA's HIMS coding procedures states that a qualified coder should review clinician-assigned codes and that the clinicians who are maintaining an acceptable accuracy rate only require random compliance reviews.⁷⁹ We found that VHA coders were reviewing all evaluation and management (E&M) codes, rather than conducting sample reviews for compliance. This approach deviates from private-sector leading practices, which are for certified coders to conduct a coding review of a sample of E&M codes per month by provider. Private-sector providers are trained on proper E&M assignment and use robust coding tools such as Computer Assisted Coding (CAC) devices to ensure codes are correct. Lack of adequate clinician training and CAC tools available nationally at VHA cause additional administrative burden for coders and contributes to the outpatient-coding backlog and high coder turnover.⁸⁰
- Interviews with coding supervisors and new coding employees revealed an over reliance on informal training practices, such as shadowing experienced employees.⁸¹ We found that the reliance on informal training for coding staff places a heavy burden on more experienced staff who are required to train new employees as well as meet their ongoing performance metrics. The ineffective coder training and inconsistent hiring of certified coders contributes to the number of controllable wrong procedure code denials received.

⁷⁶VHA Handbook 1907.03. *Health Information Management Clinical Coding Program Procedures*. (2012, September). Page 2.

⁷⁷Qualitative interviews with HIM and CBO staff revealed that this was an issue.

⁷⁸Qualitative interviews at four VAMCs indicated that this was an issue.

⁷⁹VHA Procedures. Health Information Management Services (HIMS) Clinical Coding Program Procedures. Pg 4.

⁸⁰Qualitative interview findings with three VAMCs indicated that this was an issue.

⁸¹Qualitative interviews at two VAMCs indicated that this was an issue.

During calendar year 2014, there was \$33.6 million dollars' worth of wrong procedure code denials initially received (or 3.2 percent of all denials initially received).⁸²

- This outpatient coding backlog delays the billing of a third party and risks denials for untimely submission, which directly affects the collection of amounts owed to VHA. More details regarding VHA's inpatient coder workload and productivity are located in the Assessment F (Workflow – Clinical) Report.

Recommendations

- **VA/VHA Leadership:** Collaborate with the Office of Personnel Management (OPM) to streamline the process for sourcing, interviewing, and hiring new certified coders to compete with the private sector. VHA could favorably influence their wrong procedure code denials by requiring VAMCs to hire only certified coders and by standardizing national coder training. These efforts may require VHA to engage with unions on new coder certification requirements.
- **VAMC:** In recent years, VHA has made significant advancements in virtual and self-paced training and education programs delivered via online platforms. VAMCs should leverage these platforms to train coders but consider virtual training as supplemental to formal in-person trainings. Experienced subject matter experts (SMEs) should deliver the formal in-person coding training.
- **VAMC:** Hire administrative staff members well versed in medical terminology to support coders by performing non-coding functions. Administrative staff could review open encounter reports and follow up with providers to meet documentation needs. This will allow VHA's coders to focus on coding and managing any coding backlog so that VA can avoid using coding contractors to resolve their backlog. Continue to explore the use of contracted coding staff based on demand.
- **VAMC:** Reduce coding data validation reviews for clinicians maintaining VHA's acceptable accuracy standard of 95 percent.⁸³ Coding should move toward conducting a sampling of a number of clinician-coded encounters to promote continued accuracy and compliance. Prior to initiating the coding data validation review, VHA should confirm the proper training, availability of education materials, and instruction of clinicians on clinical documentation requirements. If there are ongoing issues with compliance and a lack of confidence in the providers' documentation and coding, VHA should use CDI specialists to provide training to noncompliant clinicians.

⁸²CBO. (2015). *Total Initial Denials Received, CY2014*. [Data file and code book]. Retrieved from POWER.

⁸³VHA Procedures. Health Information Management Services (HIMS) Clinical Coding Program Procedures. Pg 4.

6.3.3 Cultural Barriers—Veterans and VHA Staff Members Do Not Consistently Understand Veteran Financial Obligations, Resulting in Inconsistent Insurance Identification and Collections.

Based on interviews with VAMC leadership, cultural barriers have a significant role in the identification of Veteran’s insurance information by VAMC Patient Access staff. VHA must have a culture of synchronized organizational functions for both VAMC Patient Intake and CPAC Patient Accounting that work toward a common goal of caring for Veterans and supporting the appropriate collection of first- and third-party revenue as outlined by Congress. A lack of shared goals contributes to weak culture and inhibits collaboration, resulting in poor outcomes. While VHA has improved its efforts to obtain insurance information from the patient, cultural barriers remain. The follow section outlines VHA’s current cultural barriers in insurance identification among Veterans and VHA staff.

Table 6-10. Cultural Barriers

<p>Cultural Barriers Defined: Informal values, norms, and beliefs that prevent an organization from achieving its mission.</p>
<p>Impact: A strong (organizational) culture is necessary to synchronize all business processes and work toward a common goal. Lack of shared goals contributes to weak culture and inhibits collaboration, resulting in poor outcomes.</p>
<p>Industry Best Practices: Strong cultures are adaptable to change, build loyalty and commitment, effectively communicate with customers, and tie operational tasks to mission accomplishment. In leading hospitals, all business processes across departments are coordinated, enabling better collections.</p>
<p>VHA Key Findings:</p> <ol style="list-style-type: none"> 1. Cultural barriers, coupled with administrative challenges, prevent VHA from maximizing collections. Veterans do not understand the need to provide insurance information, and some VHA employees do not agree with VHA’s authority to bill insurance companies for non-service connected health care.

Findings

1. **Cultural barriers, coupled with administrative challenges, prevent VHA from maximizing collections. Veterans do not understand the need to provide insurance information, and some VHA employees do not agree with VHA’s authority to bill insurance companies for non-service connected health care.**

Fifty-four point six percent of denials from insurers in 2014 were related to the Patient Intake functions, where issues with insurance verification and authorization are prevalent. Notably, non-covered charges represented the largest (35.8 percent) portion of those denials (additional

detail located in Section 6.3.5 Denials).⁸⁴ When VHA does not identify or verify insurance prior to providing scheduled services, VHA is unable to properly bill third-party insurance and perform necessary pre-authorization services, which results in denied or delayed payment for services. While VHA has improved its efforts to obtain insurance information from the Veteran, cultural barriers remain. In interviewing Patient Intake staff members, we learned two key issues that prevent timely insurance capture. These are as follows:

- a. Many Veterans do not understand why insurance information is required (many recall being promised ‘free care for life’) and refuse to provide insurance information. Other Veterans do not understand their out-of-pocket responsibilities, the CPAC refund process, or are afraid of being charged by their insurance co-payments.⁸⁵ Veterans do not understand that providing third-party insurance information and paying amounts due allows VHA to provide medical care and services to other Veterans. Interviewees reported that many Veterans are reluctant to provide insurance information or pay co-payments.⁸⁶
- b. Registration clerks do not feel comfortable asking for insurance and engaging the Veterans in this sensitive discussion. Further, some VHA staff members do not ask for insurance information because they do not believe it is appropriate to bill insurance companies for Veteran care.⁸⁷ Due to staff members not understanding the reasons to ask for insurance, lack of enforcement or Veterans unwillingness to provide this information, they do not capture insurance consistently for each Veteran.

The VAMCs run an insurance capture buffer exceptions report that indicates each time they were unable to obtain updated insurance information from a Veteran. An exception occurs when a Veteran’s health insurance requires updating and Patient Intake staff did not obtain the information from the Veteran. As depicted by Figure 6-6, VAMCs are struggling to meet VHA’s national insurance capture metric, implying an opportunity to increase performance.⁸⁸

⁸⁴ Source: National Initial Denials Received from CBO, CY2014.

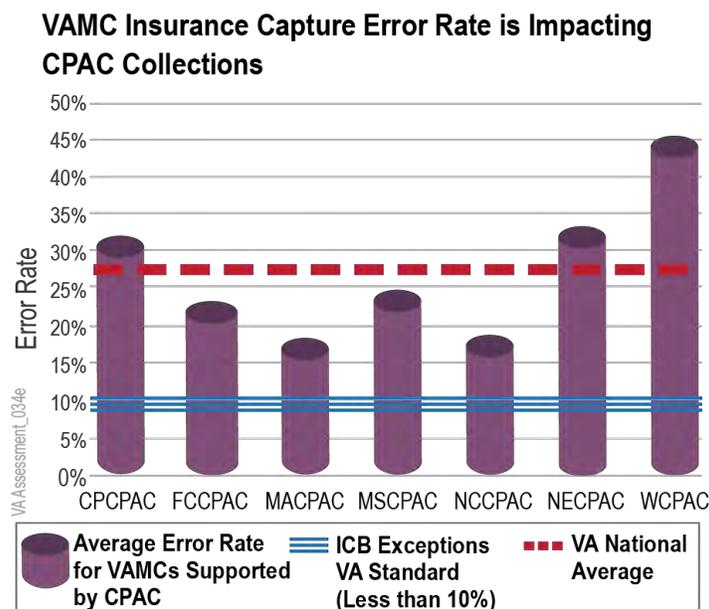
⁸⁵ Qualitative interviews at two CPACs and three VAMCs indicated that this was an issue.

⁸⁶ Qualitative interviews at two CPACs and one VAMC indicated that this was an issue.

⁸⁷ Qualitative interviews at one CPAC and one VAMC indicated that this was an issue.

⁸⁸ Assessment I Data Call. (2015). *Insurance Capture Error Rate Survey of 123 of 139 VAMCs*. Unpublished raw data.

Figure 6-6. Insurance Capture Error Rate



Source: VAMC Insurance Capture Error Rate Data Call Results. ICB exception rate data for Calendar Year 2014 was obtained via a VAMC-wide data call. There were 123 VAMC respondents that provided their error rate. An average error rate for VAMCs support by CPAC was calculated at the CPAC level.

- Our finding is consistent with a 2012 OIG Report, which found that VHA needed to improve their processes for identifying Veterans with third-party insurance (OIG, 2012). Per the 2012 OIG Report:⁸⁹
 - “VA medical facility revenue staff did not bill approximately 400,000 or three percent of over 16 million unbilled episodes of care because Veterans or their spouses’ insurance policies were not identified at the time of treatment or within the insurance billing time frame.”
- OIG recommended that VHA implement mechanisms to monitor insurance identification and to train clinical administrative staff on third-party insurance identification policies and procedures. In reviewing VHA’s insurance capture data and interviews with CPAC and Patient Intake staff, it appears that the OIG’s 2012 recommendations were not implemented effectively.

Recommendations

- **VHA:** Near-term actions include increasing communication to Veterans and VHA staff using VAMC Town Hall meetings, website resources, and existing staff and Veteran

⁸⁹ Department of Veterans Affairs Office of Inspector General. (2012). Audit of VHA’s Medical Care Collections Fund Billing of VA-Provided Care. Report No. 11-00333-254. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf>

training as mechanisms to emphasize the insurance collection requirement. Include this education in mandatory, periodic refresher training for all VHA staff.

- **VHA:** Institute and mandate a process to identify third-party payer coverage at or near the point of scheduling, or at a minimum within 72 hours of the scheduled service. Doing so will reduce the risk of not capturing insurance until later in the process (e.g., Patient Intake).
- **VHA:** To address the larger cultural barriers, VHA should incorporate education of Veterans, their families/caretakers, all levels of VHA staff, key stakeholders (including Congress and state/local government agencies, Veterans' groups), and the public, into their Strategic Communications Plan. The education should focus on the legislative requirements for third-party insurance identification and collection, and the importance for Veterans to ensure the long-term viability of the VHA health care program.
- **VAMC:** Consistently communicate the benefits of insurance identification and verification to both Veterans and VHA staff. Patient Intake and Scheduling staff need to understand how important insurance information is to their own VA Medical Center's financial standing, and that allows it them to better serve Veterans. It is important for any communication efforts to help Veterans understand how insurance works at VHA, how co-payments are collected and reimbursed, and how funds are used to provide additional services for Veterans. Veteran training should include financial responsibilities in the benefits information sent to each Veteran, potentially through issuance of a card (that details co-payment amounts).
- **VAMC:** Invest in recurring training program to reinforce to Patient Intake staff the benefits to the VAMC of collecting third-party insurance information. For example, help new clerks understand the amounts collected are ultimately returned back to the VAMC. Better-informed clerks will enable the confidence required to inquiring about and obtaining Veteran insurance information, leading to improved collections for VHA.

6.3.4 Patient Accounting—Opportunities to Increase Collections Exist.

At VHA, the CPACs oversee all billing, accounts management, claims follow up, denials management, first-party follow up, cash applications and adjustments, customer service, vendor management, insurance verification, utilization review, and payer relations.⁹⁰ We evaluated VHA's key performance metrics for comparison to the private sector, the performance between the CPACs and the performance against the VHA standard. We evaluated the collections to billings and GDRO metrics for Patient Accounting. Appendix D, Standards and Benchmarks, provides our summary of key private-sector benchmarks compared to related VHA measures. Additionally, we attempted to evaluate days to bill as a key performance indicator; however, we did not evaluate this metric due to lack of comparability to the private-sector benchmark.

⁹⁰Note: Regional payer relations is covered in Chapter 9.

Table 6-11. Patient Accounting

Patient Accounting Defined:

Patient Accounting is comprised of Billing, Accounts Management, and Payer Relations. VHA refers to the submission of claims to the first-party (Veteran) and third-party (insurance company) as billing. Accounts Management activities occur after billing and focus on timely follow-up and payment of unpaid amounts (aged AR) from payers. Payer Relations is the provider function responsible for establishing contracts with third-party payers, negotiating payment rates, and ensuring the accuracy and compliance of third-party payments in accordance with negotiated contracts.

Impact:

Billing the correct amount and ensuring amounts billed are collected promptly are key drivers to overall financial performance of the revenue cycle. Additionally, Payer Relations negotiates reimbursement terms with contracted payers and supports enforcing third-party payer adherence to agreed-upon terms (including payment terms).

Industry Best Practices:

Claims are billed with automated tools that support ensuring accuracy and appropriateness of billed amounts. Accounts management teams, organized by large and small balance units, follow-up with payers on unpaid bills and ensure timely payment. Payer Relations negotiate contracts to create uniform agreements that allow for standardization and automation of patient accounting functions. An integrated billing and payer contracting system exists to systematically verify bills comply with payer contracts.

VHA Key Findings:

1. VHA collections, as a percent of billings, has decreased over the last three years despite the growing maturity of the CPACs (the last CPAC was operationalized in 2012).
2. While the CPACs have improved standardization of billing and collection processes, process inefficiencies and talent management issues were evident.

Finding 1

1. VHA collections, as a percent of billings, has decreased over the last three years despite the growing maturity of the CPACs (the last CPAC was established in 2012).

- The CPAC model has improved performance across key revenue cycle functions as it matured over time. However, a key metric, the percent of third-party collections to billings decreased from 39.2 percent to 36.5 percent over the three-year period from January 2012 to December 2014.^{91,92} As the amount of billings rose by nearly \$200 million during that time, we would typically anticipate that collections would trend in a similar

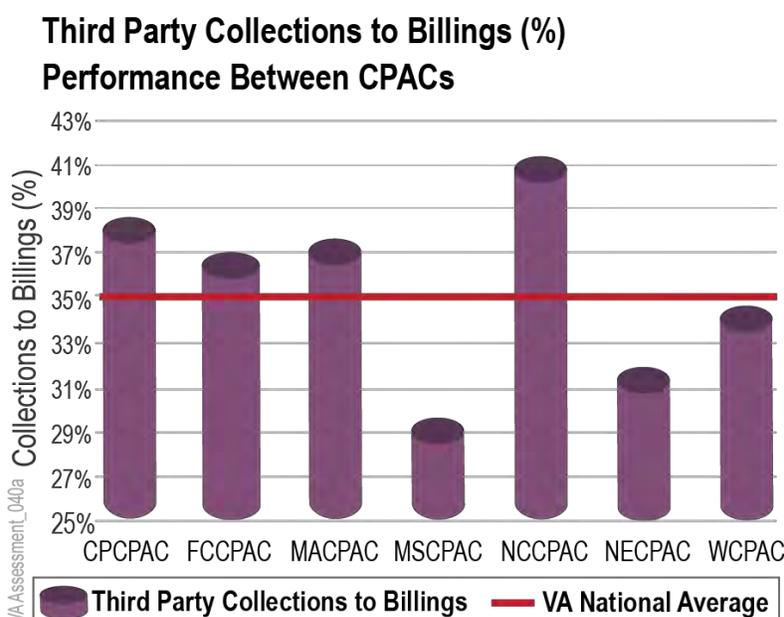
⁹¹CBO. (2015). *National Third Party Collections as a Percent of Billings, CY2012-CY2014*. [Data file and code book]. Retrieved from POWER.

⁹²Note: Based on private sector calculation (Collections to Billings percent = Total Collections/ Total Billings) for a given time period.

manner. We understand additional variables affect this trending, such as price increases, changes in reimbursement terms, new payer contracts, changes in payer mix and/or changes in the volume and types of services provided. Evaluating the effect of these variables was not within the scope of this assessment.

- The 2014 third-party national collection to billings percentage was down to 34.8 percent from 35.7 percent in 2013; however, it slightly improved from the 2012 performance of 34.3 percent.⁹³
- Figure 6-8 represents the CPAC’s performance of collections as a percent of billings for calendar year 2014. The North Central CPAC with a collection rate of 40.8 percent has the highest collection rate in relation to the other CPACs.

Figure 6-7. Collections Related to Billings – CY2014^{94,95}



Source: CPAC Third Party Collections to Billings from CBO, CY2014

- VHA measures collections to billings as a key performance indicator in their revenue cycle reporting tool; however, due to calculation variations from industry standard, we could not effectively analyze this metric. CBO tracks third-party collections to billings by comparing collections to the bills to which they directly correlate. VHA excludes uncollected bills from the calculation. This is not consistent with the industry standard

⁹³CBO. (2015). *National Third Party Collections as a Percent of Billings, CY2012-CY2014*. [Data file and code book]. Retrieved from POWER.

⁹⁴CBO. (2015). *CPAC Third Party Collections to Billings, CY2014*. [Data file and code book]. Retrieved from POWER.

⁹⁵Note: Billings and Collections data based on calendar year 2014. National average of 34.8 percent calculated using data from same timeframe. San Juan is excluded from FCCPAC analysis due to unique payers not on electronic billing.

calculation that includes total billings in a given timeframe and not just collected billings. By calculating the metric using the industry standard, the third-party collections to billings ratio for calendar year 2014 was approximately four percent lower than when calculated using the VHA method. This percentage difference is accounted by billings that are unpaid and in AR or potentially adjusted/written-off.

Recommendations

- **CBO/VHA/CPAC/VAMC:** If VHA addresses and standardizes the issues and recommendations listed in this report, it will improve the CPAC's collections as a percent of billings.⁹⁶
- **VHA/CBO:** Calculate and report collections to billings using traditional industry approaches.

Finding 2

2. Patient accounting experiences process inefficiencies and talent management issues.

- A common theme across our interviews was that billers could not keep up with their productivity goals and accounts management requires a significant amount of rework.⁹⁷ Billing staff turnover is an issue due to the low pay grade of the positions. Interviewees noted that many billers view their position as a stepping-stone to another role with a higher pay grade, leading to high turnover and a constant need to train new staff. VHA billing technicians are currently a GS5 on the federal pay scale, which is a lower rating than other CPAC departments and in turn leads to employee turnover. Billers move into other departments as opportunities arise.
- Another process inefficiency that negatively affects the time to collect is the division of work within accounts management follow up, where the distributed workload does not follow designated dollar thresholds.⁹⁸ The accounts management "follow up" team is currently split in two teams: (1) the "follow up" team whose designated dollar threshold to work billed claims with accounts receivable balances between \$251 and \$4,999, and (2) the denial management team whose designated dollar threshold is to work billed claims with accounts receivable balances greater than \$5,000. Routed work load does not follow these designated thresholds as low dollar issues are routed to the high dollar denial management team work queue (e.g., underpayments, providers, and coding issues are primarily low dollar issues < \$1,500 that are funneled to the high dollar denial management team work queue).

⁹⁶Note: Similar to the private sector, collections as a percent of billings are also influenced by trends such as price increases, changes in reimbursement terms, new payer contracts, changes in payer mix, and/or changes in the volume and types of services. CBO should consider these factors as it evaluates collections as a percent of billing at each CPAC going forward.

⁹⁷Qualitative interviews at three CPACs VAMCs indicated that this was an issue.

⁹⁸Qualitative interviews at three CPACs VAMCs indicated that this was an issue.

- In addition to distribution of work duties, we would not expect to see as many billing FTEs as compared to the accounts management follow up FTEs. This is partially explained by the high number of biller FTEs that are required due to manual nature of generating bills. For example, at the time of our site visit, the North Central CPAC had 64 billing FTEs (not including 10 vacancies), 24 “follow up” FTEs working balances between \$251 and \$4,999, and eight denial FTEs working balances greater than \$5,000. As a result of the division of labor, more FTEs are billing claims and focused on low dollar claim follow up versus high dollar account balances.⁹⁹

Recommendations

- **VHA:** Reevaluate the appropriate GS level to perform the billing function and collaborate with the Office of Personnel Management (OPM) to change the requisite pay grade level.
- **CPAC:** Reorganize the accounts management team so that the large balance unit is proactively working and resolving approximately 80 percent of the AR dollar balance. The small balance unit should reactively work and resolve 20 percent of the dollar balance of AR (typically comprised of 80 percent of account volumes), as is the industry standard. The number of accounts assigned to large balance and small balance should reflect private industry standards whereby large balance personnel are assigned lower volumes of accounts than small balance personnel. If resources exist, consider further organizing the large balance unit and small balance unit by payer to develop rapport and expertise with a payer that accelerates resolution of outstanding claims.
- **CPAC:** Continue to explore and evaluate contracting out routine follow up functions.

6.3.5 Denials

The CPAC is responsible for tracking and responding to denials from third party insurers. Third-party denial rates depict bills for medical services provided which a payer (the insurer) has rejected. Denials result in decreased collections and occur for myriad reasons. CPAC staff assigns each denial a rejection code, and typically aligns the denial to a function within the providers’ revenue cycle. As such, third-party denials provide a strong indication on the effectiveness of an organization’s business operations and the health of a revenue cycle program. A denied claim has the potential to represent lost or delayed collections from a third-party insurer and illustrates the accuracy and efficiency of VHA’s revenue cycle.

The Accounts Management team at the CPACs receive denials from third-party insurers and conduct root cause analyses to understand and resolve the denial. A Denials Management Specialist in the quality department at the CPACs performs root cause analyses of denials and works with the business functions (both at the CPAC and VAMCs) to remediate and prevent denials from recurring. Coordination between business functions is necessary to resolve most denials.

⁹⁹Qualitative interviews at three CPACs VAMCs indicated that this was an issue.

Table 6-12. Denials

<p>Denials Defined:</p> <p>Denials occur when a third-party payer initially refuses to pay a claim due to a provider not adhering to specific policies/procedures or the payer requests additional information.</p>
<p>Impact:</p> <p>Analyzing and correcting claims from the denial resolution process represents opportunities to increase collections, and prevent mistakes from recurring.</p>
<p>Industry Best Practices:</p> <p>Seamless coordination across Patient Access, Clinical Administration, and Patient Accounting functions prevent a majority of denials. Effective denials management practices include regular reviews of denials by a denial management committee of key revenue cycle and administrative stakeholders, standardizing recovery processes, efficient third-party contacts management, and developing approaches to resolve frequently recurring denials proactively. These activities are key to improving financial performance.</p>
<p>VHA Key Findings:</p> <ol style="list-style-type: none"> 1. Third-party collections delayed or denied by insurers due to ineffective insurance identification in Patient Intake. 2. Third-party collections are delayed or denied by insurers due to issues that arise from a lack of coordination across VHA's revenue cycle. 3. Patient Intake, Coding, and Patient Accounting functions are not integrated resulting in disparate processes and lack of coordination across the revenue cycle.

Table 6-13 depicts a summary of the total denials for calendar year 2014 received by all seven CPACs.¹⁰⁰ The table includes a comparison of VHA's initial denial received rate of 22.9 percent versus the Healthcare Financial Management Association's (HFMA) leading practice metric of 4 percent.¹⁰¹ This large variation highlights a significant opportunity for improvement within VHA's revenue cycle processes.

Table 6-13. Total Initial Denials Received – CY2014¹⁰²

CY 2014 Total	\$/%
Total Billed (\$)	\$5,992,545,661
Total Initial Denials Received (\$)	\$1,371,836,531

¹⁰⁰CBO. (2015). *Total Initial Denials Received, CY2014*. Retrieved from POWER. Reported in POWER by CPAC and totaled to report Total Initial Denials Received for calendar year 2014.

¹⁰¹Notes: The Healthcare Financial Management Association (HFMA) is a well-recognized source of revenue cycle management benchmarks for the health care industry.

¹⁰²For CY 2014 \$3,176,041,415 was received in collections. Denials presented are denials initially received versus denials posted

Assessment I (Business Processes)

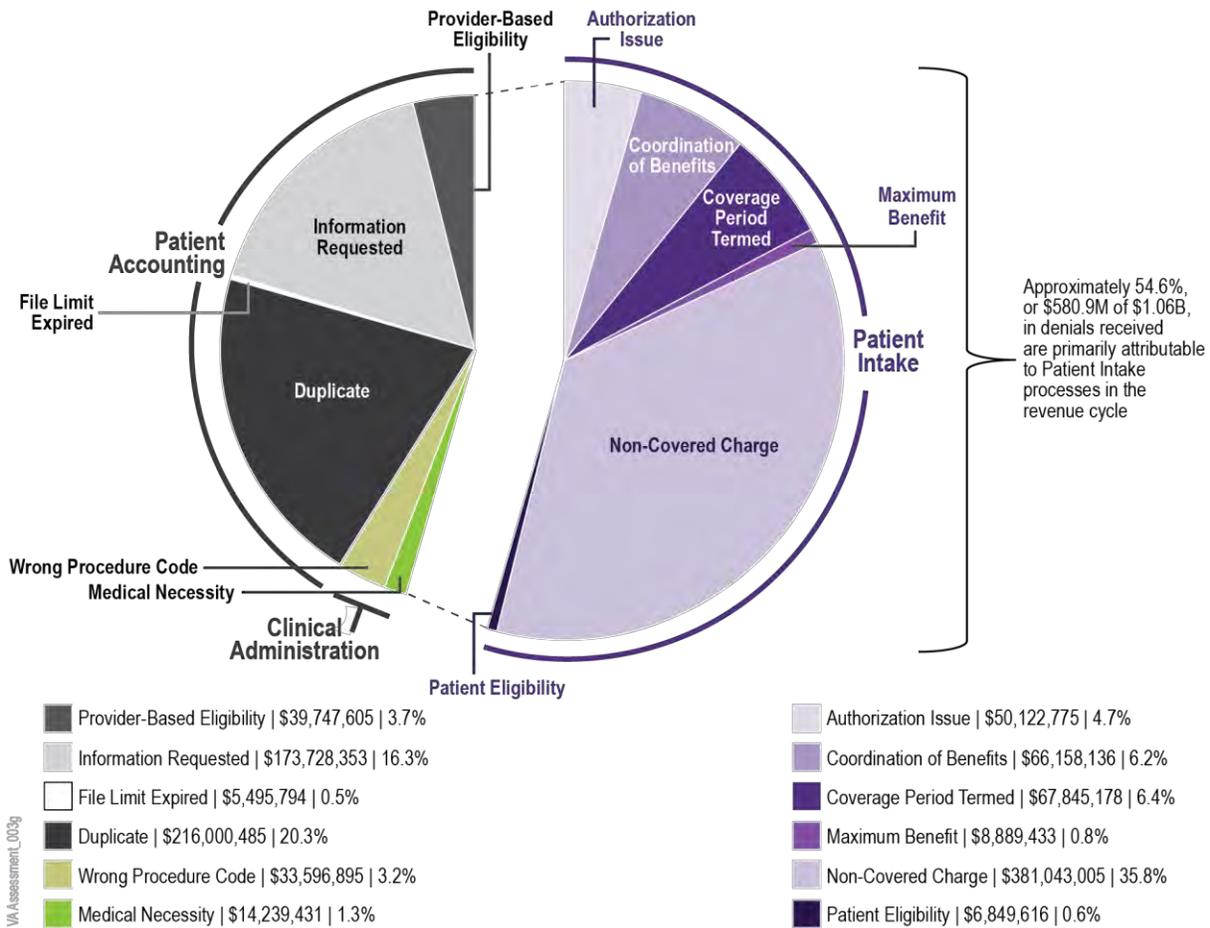
CY 2014 Total	\$/%
Total Initial Denials Received (%)	22.9%
HFMA Initial Denial Rate (%)	4.0%
Variance from Best Practice (%)	18.9%
Variance from Best Practice (\$)	\$1,132,134,705

Source: Total Initial Denials Received from CBO, CY2014

Figure 6-8 depicts a summary of the calendar year 2014 denials received by all seven CPACs and includes the dollar and percentage of the top 80 percent denials received. A large proportion of VHA's denials is controllable and could be resolved through enhanced upfront insurance identification and verification. The lack of accurate and timely insurance identification and verification results in non-payment due to issues with pre-authorization, coordination of benefits, patient insurance coverage period termed, non-covered charges, and patient not eligible or covered by insurance at date of service.¹⁰³ Refer to Appendix A-1 for a summary of denial categories, the definition, the corrective action and our recommendations to correct the business processes surrounding the denial category.

¹⁰³Note: Note all denials are attributable to VHA. Denials for maximum benefit reached and non-covered charges may not be reimbursed. These denial categories may be due to the patient's insurance plan, charge description master issues, payer contracting issues, and other categories.

Figure 6-8. Reasons for VHA Payment Denials (CY 2014)



Source: Author Rendition based on National Initial Denials CY2014 data provided by CBO

Figure 6-8 displays the distribution of the top 80 percent, based on dollar amount, of VHA denials received nationwide for calendar year 2014. VHA received a total of \$1.372B worth of denials in 2014, the top 80 percent of these denials totaled \$1.063B. VistA tracks all transactions with an insurer on a claim. When a line item or specific charge denial is received from an insurer the total balance of the claim is counted as a denial; therefore, denial amounts may be artificially inflated.

Finding 1

- 1. Third-party collections are delayed or denied by insurers due to ineffective insurance identification, verification, and preauthorization in Patient Intake.**

- VHA's third-party denials initially identified as primarily attributable to Patient Intake/VAMC processes make up \$508.9 million or 54.6 percent of the top 80 percent of denials received in calendar year 2014.¹⁰⁴
- In reviewing VHA's denial category data, we found that high denial rates are occurring because Patient Intake staff did not obtain and identify patients' information (demographic and insurance).
- When Patient Intake staff members do not identify and update insurance information, billing errors result in third-party payment denials. Such denials require additional efforts to resolve and may result in lost revenue.
- Patient Intake staff members, as is customary in private sector, do not complete preauthorization prior to a Veterans appointment. Furthermore, due to late insurance identification, the CPAC Utilization Review Nurse does not routinely obtain pre-authorization *before* treatment is rendered, resulting in payment denials.

Recommendations

- **VAMC Leadership:** Require the identification of third-party insurance at scheduling and pre-registration by VAMC Patient Intake staff. Electronically verify all insurance prior to date of service to allow CPAC nurses to obtain necessary preauthorization timely.
- **CPAC:** Perform a regular root cause analysis of non-covered charges related to Patient Intake issues. This analysis should include identification of charges not covered that relate to only a portion of services provide, charge not covered due to charge description master issues, payer contracting issues, and other categories. The results of this would be to identify common trends in non-covered charge denials and develop preventive work plans to prioritize correctly.
- **VAMC:** Enhance the patient self-service kiosks with technical capabilities to scan insurance cards and to include system rules that prevent the patient from completing the registration process if the insurance information on file is missing or expired.

6.3.6 Organizational Alignment – Separate lines of accountability for Revenue Processes across VAMCs and CPACs negatively affects collections.

The revenue processes span across VAMC and CPAC responsibilities and processes; however, only the CPACs are responsible for revenue collection and the associated performance outcomes.

Finding 1

1. **Third-party collections are delayed or denied by insurers due to issues that arise from a lack of coordination across VHA's revenue cycle.**

¹⁰⁴CBO. (2015). *Total Initial Denials Received, CY2014*. Retrieved from POWER. Reported in POWER by CPAC and totaled to report Total Initial Denials Received for calendar year 2014.

- We learned through interviews that Billing, Accounts Management/follow up, and insurance verification units, which are located at the CPACs, do not communicate and coordinate enough with Patient Intake and Coding at the VAMCs.¹⁰⁵ While we understand communication has improved in recent years, the lack of accountability across these key revenue cycle functions inhibits optimal collaboration on systemic issues.

Recommendation

- **VAMC and CPAC:** Create a cross-functional denial management committee at each VAMC to increase collaboration between the professionals in Patient Intake, Coding, and Billing. Consistent with private-sector best practices, the committee should meet monthly at a minimum and comprise of the key stakeholders in Patient Intake, Clinical Administration and Patient Accounting.

Finding 2

2. Patient Intake, Coding, and Patient Accounting functions are not integrated resulting in disparate processes and lack of coordination across the revenue cycle.

- The VAMC/VISN currently owns Patient Intake and Coding activities. VHA's national Health Information Management Service, comprised of Coding leaders do not have authority over coders. Coders report locally, to VAMC leadership. Patient Accounting is an activity within the revenue cycle that is dependent on successful execution of Patient Intake and Coding functions. Patient Accounting reports to CBO, unlike Patient Intake and Coding. Driven by the separation between business process and structure within the revenue cycle, there is a lack of coordination across the revenue cycle continuum.¹⁰⁶

Recommendations

- **VHA:** Assign shared responsibility between Patient Intake and Clinical Administration (e.g., coding) with Patient Accounting for revenue collection outcomes and include specific goals in management/staff performance plans as a near-term improvement.
- **VHA:** In the longer term, consider and evaluate the benefits of aligning patient intake and coding functions under CBO. Evaluation should consider the benefit of aligning coding under VHA's national HIMS and subsequently, HIMS under CBO. Organizationally aligned business functions provide greater opportunity for successful performance management and establishment of organizational accountability. Private-sector leading practices are to align all components of the revenue cycle under the CFO linking job responsibilities to financial performance.

¹⁰⁵Qualitative interviews at three CPACs and two VAMCs.

¹⁰⁶Qualitative interviews at three CPACs and four VAMCs.

6.3.7 First Party Collections – VHA Could Increase First Party Collections through Financial Education and Point of Service Collections.

First Party collections refers to co-payment amounts due from the patient. Effective financial counseling is a significant component of Patient Intake, directly influencing Veteran satisfaction and first-party collections. Industry leading practices are to train Patient Intake personnel to appropriately identify and communicate out of pocket responsibilities and alternatives for covering expenses to patients. Patients are instructed to be prepared to meet financial obligations *prior* to or on the day of the scheduled appointment.

Table 6-14. First Party Definition

<p>First Party Defined: First party refers to the patient/Veteran</p>
<p>Impact: Patients need to understand their roles and responsibilities in regards to benefits and out of pocket expenses. Educating Veterans will increase collections to the provider of non-service connected care if the Veteran has other health insurance. Without financial education to help the patient understand his/her insurance coverage and financial responsibility for health care services, loss of revenue may occur, directly affecting the collection of amounts owed to VHA for non-service connected care.</p>
<p>Industry Best Practices: Out of pocket amounts due should be collected on the date of service. VHA should provide financial counseling prior to services performed to assist patients in understanding costs and alternatives for covering such expenses.</p>
<p>VHA Key Findings:</p> <ol style="list-style-type: none"> 1. VHA provides inconsistent education on financial responsibilities to Veterans at point of service, inhibiting understanding of their financial obligations at VAMCs upon check-in and negatively affecting first party collections. 2. Collections are not maximized due to VHA’s inability to collect release of information forms (ROI) from Veterans at the point-of-service.

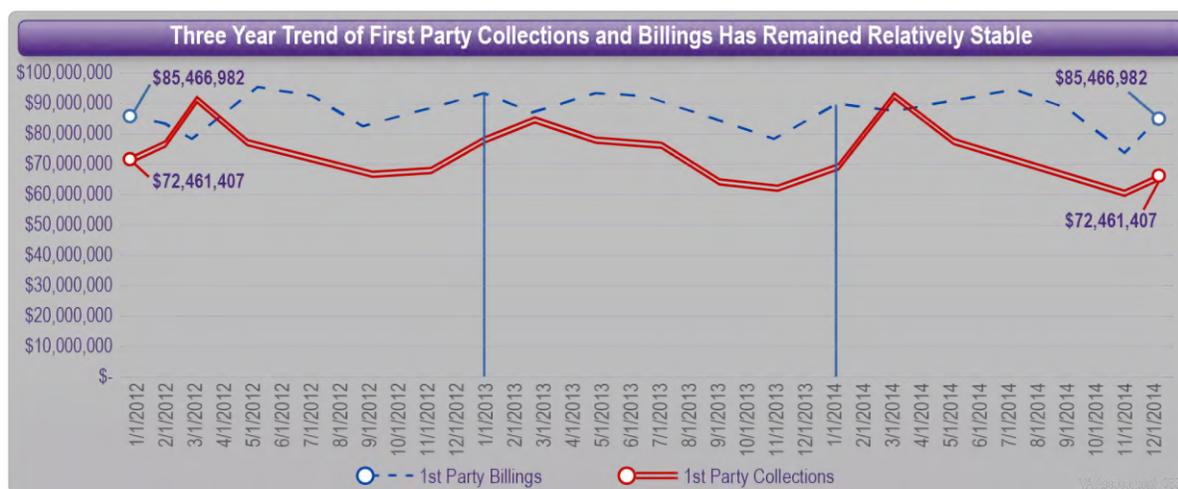
VHA begins first-party collections at the CPAC after encounters are complete. If the patient care is not service connected and out-of-pocket expenses are owed, a patient bill is automatically generated 90 days after services are rendered (the 90 day period was established to allow time to identify third-party insurance) and sent to the patient.¹⁰⁷ Following the initial 90-day period, VHA provides the Veteran with three statements over a 90-day period. Each statement reflects total amounts due and directs the Veteran to where they can get help with questions.

¹⁰⁷ Note: VHA does not bill a Veteran before the date of their service.

Additional detail regarding co-payments and eligibility is located in Appendix 10A.2.5.2 Eligibility and Coordination of Benefits.

Figure 6-9 depicts the national collection rate of first-party payments compared to first-party billings for the period January 1, 2012 to December 31, 2014.¹⁰⁸ On average, VHA collects first-party payments between 30-60 days after VHA releases the initial bill. VHA's collection performance has remained relatively stable over the past three years. The annual rise of collections during the month of March corresponds to increased collections from Veteran's upon filing federal and state taxes, and setting up repayment plans with the CPACs. After approximately 90 days, VHA sends any nonpaid Veteran bills to VHA's Debt Management Center (DMC) for collection. If collection efforts remain unsuccessful, DMC transfers the bills to the Treasury Offset Program (TOP). Both programs contribute to VHA's first-party collection performance.

Figure 6-9. National First Party Billings and Collections^{109,110}



Source: National First Party Billings and Collections from CBO, CY2012-2014

Figure 6-9 reflects the total first-party collections as a percent of billings for calendar year 2014 by CPAC and as a national average. In Figure 6-9, CPCPAC (Central Plains) is reflected as the top performer amongst the CPACs in 2014 in comparison to VHA's national average. The MACPAC had the lowest performance of the seven national CPACs. Performance may vary between the CPACs given the population of Veteran's, the Veteran's ability to pay, Veteran education and influence of other factors (e.g., local economy).

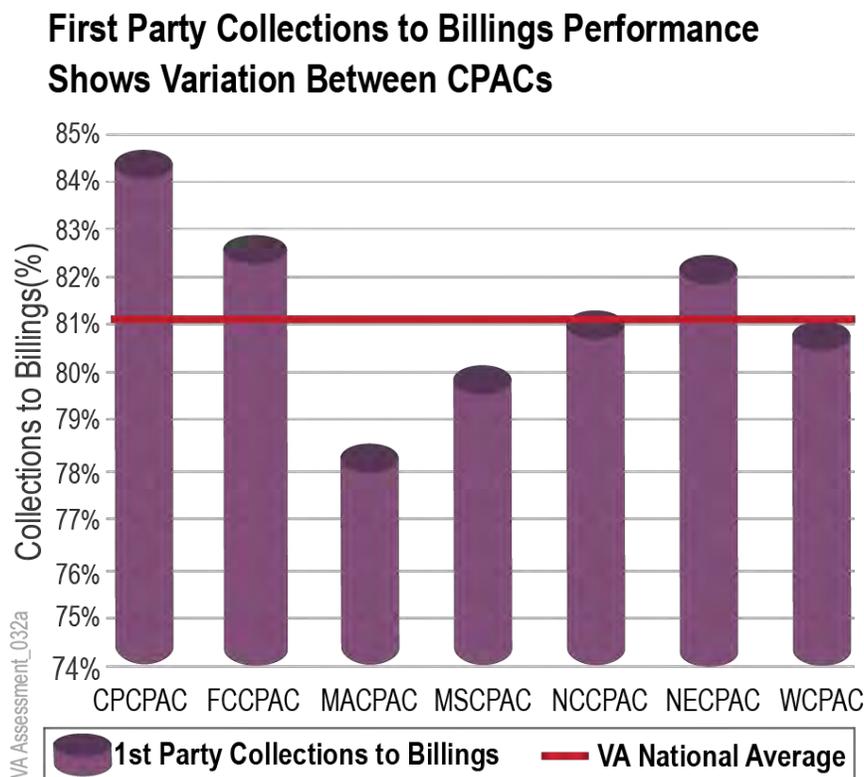
¹⁰⁸ CBO. (2015). *National First Party Collections and Billings, CY2012-CY2014*. [Data file and code book]. Retrieved from POWER. Reported in POWER by CPAC and totaled to report National First Party Billings and Collections for calendar year 2014.

¹⁰⁹ CBO. (2015). *National First Party Collections and Billings, CY2012-CY2014*. [Data file and code book]. Retrieved from POWER.

¹¹⁰ Note: First party billings and collections include inpatient, outpatient, pharmacy, and long term care co-payments.

Per HFMA, private-sector hospitals should strive to collect 65 percent of patient pay (or first-party) balances prior to inpatient discharge and 75 percent of patient pay balances prior to outpatient service (HFMA, 2012). The private-sector metric is not an appropriate baseline for VHA’s First-party process for three reasons: (1) VHA collects well after the service is provided, (2) VHA waives co-payments for Veterans with insufficient financial means, and (3) VHA waives the co-payment for Veterans within Priority Groups (see Appendix 10A.2.5.2 Eligibility and Coordination of Benefits).

Figure 6-10. First-party Collections as a Percent of Billings for CY2014¹¹¹



Source: CPAC First Party Collections to Billings from CBO, CY2014

Finding 1

- VHA provides inconsistent education on financial responsibilities to Veterans at point of service, inhibiting understanding of their financial obligations at VAMCs upon check-in and negatively affecting first party collections.**
 - Due to differences in Veteran’s co-pay amounts based on service connectedness and priority groups, Veterans have varying co-payment obligations when seeking care at VHA. This can become confusing for Veterans and VHA staff. During interviews, we noted some VHA staff lack a full understanding of patient obligations due to inadequate training and

¹¹¹CBO. (2015). *CPAC Collections and Percent of Billings, CY2014*. [Data file and code book]. Retrieved from POWER. Data was reported by CPAC.

inconsistent communication from VHA. Further, staff members do not always ask correct follow-up questions when speaking with a Veteran (OIG, 2012).

- VHA bills patients for VHA co-payments 90 days after their date of service. Co-payments are not collected at point-of-service, as is customary in private sector.¹¹² We understand this is due in part to service connected determinations, late insurance identification and outdated income verification (VHA refers to as “means test”).
- Based on sites visited, we also found that VAMCs provide insufficient financial counseling to non-service connected patients. Financial counseling is an in person, one-on-one interaction with the Veteran to explain out of pocket responsibilities. There are CPAC staff members (Facility Revenue Technicians) stationed at each VAMC to counsel patients if they have a question or complaint regarding a bill, but the Facility Revenue Technicians (FRT) are separated from the registration desk/area and do not provide proactive financial counseling to all patients. Similarly, the OIG identified missed First-party collection opportunities during point-of-service encounters due to inadequate staff training and Veterans not understanding their financial obligations. The OIG reported that registration clerks were not educating patients on their financial responsibilities (OIG, 2012).
- Two of the VAMCs we visited offer patients the one-time opportunity upon enrollment to participate in an optional educational class at the VAMC to receive financial counseling. In the private sector, readily available one-on-one counseling is customary.

Recommendations

- **VHA/CBO:** Upon implementation of related recommendations in this report (i.e., Culture, Simplification of Rules, Organizational Alignment), CBO should ultimately plan to collect co-payments at point of service, prior to treatment. Develop and implement a standard point-of-service collections policy directing VHA staff members to identify and request co-payments at each appointment prior to the patient leaving the facility.
- **CBO:** Standardize policies to ensure that if late insurance is identified, collection efforts on First-party obligations begin with written communication no later than 30 days after date of service. Communication should occur over routinely a 90 to 120 day period.
- **CBO:** Invest in online tools for pre-registration and registration that allow for real time explanation of Veteran out-of-pocket expenses. Technological solutions should account for Veteran’s service connected status, priority group and diagnosis when relaying out-of-pocket expenses. The technological solution should be coupled with the issuance of a card to each Veteran with individual co-payment information encoded.
- **VHA Leadership:** Reexamine VHA’s co-pay policy and structure within the Veteran Priority Groups to determine if simplification is feasible (refer to Appendix A Background VHA Care Revenue-First-party Collections) as well as improve the tracking and monitoring payments to VHA co-payment guidelines. For instance, we understand VHA has mandated

¹¹²Qualitative interviews at three CPACs provided this process overview. Private-sector co-payment collection standard is based on feedback from industry subject matter experts.

that all co-payments to be refunded to Veterans once insurance companies pay billed amounts exceeding the co-payment. The intent is to incentivize Veterans to provide insurance information for non-service connected treatment. Upon implementation of culture and organizational recommendations, we suggest VHA explore avenues to cease the manual and cumbersome co-payment refund process (additional detail in the IT section). Further, a streamlined approach to service connected determinations, means testing, and financial counseling will result in increased first party collections.

- **CPAC:** Evaluate staffing requirements for FRTs at each VAMC, evaluate FRT's workload, and prioritize responsibilities amongst the FRTs and their managers. Make available a FRT at Patient Intake of each VAMC to provide direct, one-on-one financial counseling for non-service connected treatment in an effort to enhance Veterans' understanding of their financial responsibilities.
- **VAMC:** Standardizing Patient Intake staff training materials, including scripts that highlight out-of-pocket obligations for all VHA staff that interact with Veterans. This will allow all Veterans to receive a uniform response regardless of the VHA staff with whom they speak.
- **VAMC:** Leverage existing Veteran outreach and education programs, as well as collaborate with outside Veteran Service organizations (e.g., VFW), to publish financial responsibilities regarding out-of-pocket expenses and CPAC financial assistance policies. This information should also be readily available on VHA's web site with a 1-800 telephone number for Veteran questions, in addition to printed material at Veteran Service organizations and VAMCs. Consider consolidating all Veteran education material in a pocket-sized format, which would allow Veterans to have all pertinent information in an easy to access guide.
- **VAMC/CPAC:** Standardize the one-time Veteran education class. The material should cover Veteran co-payment requirements and rates, overview of Veteran health benefits and eligibility, as well as financial distress programs to assist Veterans pay co-payment requirements.

Finding 2

2. Collections are not maximized due to VHA's inability to collect Release of Information forms (ROI) from Veterans at the point-of-service.

- 38 USC §7332 and implementing regulations (sections 1.460- 1.499) requires VHA to obtain a patient release of information for all care related to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia. ROI forms (VA Form 3288) are created by VHA to authorize the release of the Veteran's information to third-party insurance carriers. Veterans complete the ROI forms post care and currently they are not being completed promptly.
- VHA cannot submit a claim to the third-party payer until after receiving a signed ROI form. When a Veteran does not sign it, this results in lost revenue for VHA. VHA does not currently have the ability to report the amount of lost revenue from missing ROI forms, but interviews at the CPAC indicate it is substantial.

Recommendations

- **VAMC:** Conduct mass mailing of VA Form 3288 (ROI form) to all Veterans currently enrolled to obtain Release of Information signatures. Implement process for Veteran to sign one all-inclusive ROI that is attached to the 10-10EZ (Application for Health Benefits). Veteran would be required to sign this during initial VHA enrollment, and is all-encompassing, and upload forms to VistA where scheduling and registration staff can verify and change. Additionally, develop and implement a standard registration/check-in procedure directing VAMC Patient Intake staff to collect a completed ROI form for those who have not previously signed it.¹¹³
- **VHA/CBO Leadership:** Make ROI forms available online and build all-inclusive ROI functionality into the check-in kiosk system. Patients should be prompted to complete and authorize the form, but not be required to, when using the kiosks prior to being seen by a provider. This added functionality would support further automation of key VHA systems and improve administrative efficiencies for VHA staff.
- **VHA/CBO:** If ROI issues persist after implementing these recommendations, align ROI completion compliance to performance standards for patient intake and VAMC leadership staff to drive accountability.

6.4 Summary of Findings and Recommendations

The following table summarizes the findings and recommendations presented in this chapter, providing further detail to identify each finding’s significance and each associated recommendation’s timeline and effect.

Table 6-15. Summary of Findings and Recommendations

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
Cultural barriers, coupled with administrative challenges, prevent VHA from maximizing collections.	Increase communication to Veterans and VHA staff. Institute and mandate a process to identify third-party payer coverage at or near the point of scheduling.	Tier 1	Short	Process, People, Technology
Third-party collections delayed or denied by insurers due to ineffective insurance	Require the identification of insurance at scheduling and pre-registration by	Tier 1	Short	Process, Technology

¹¹³Note: VA staff referred us to Title 38, Section 1.576, stating that it prevents them from proactively collecting ROIs prior to services. However, our review of the legislation did not confirm this.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
identification in Patient Intake.	VAMC Patient Intake staff.			
VHA lacks standard scheduling practices and the requirement to identify insurance at the time of scheduling, inhibiting timely insurance capture.	Update VHA Directives to require the identification of third-party payer coverage at or near the point of scheduling.	Tier 1	Short	People, Process, Technology
Delays in clinical documentation turnaround time are inhibiting timely coding, billing, and third-party revenue collection.	Enforce national targets for clinicians to complete notes within 24 hours and medical records within seven days, and use performance pay agreements to assist with enforcement.	Tier 1	Short	People, Process, Technology
VHA is not consistently implementing and enforcing the national initiative around improving clinical documentation practices.	Standardize the CDI program and mandate use across all VAMCs by providing designated CDI specialist funding.	Tier 1	Short	Process, Technology
Third-party collections are delayed or denied by insurers due to issues that arise from a lack of coordination across VHA's revenue cycle	Assign shared responsibility between Patient Intake and Clinical Administration (i.e., coding) with Patient Accounting for revenue collection outcomes and include specific goals in management/staff performance plans as a near-term improvement	Tier 1	Medium	People, Process
Patient Intake, Coding, and Patient Accounting	Assign shared responsibility between	Tier 1	Medium	People, Process

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
functions are not integrated resulting in disparate processes and lack of coordination across the revenue cycle	Patient Intake and Clinical Administration with Patient Accounting. Align the Patient Intake and Coding functions under CBO.			
Patient accounting experiences process inefficiencies and talent management issues.	Reevaluate the appropriate GS level to perform the billing function. Reorganize the accounts management team	Tier 2	Medium	People, Process
Limited and ineffective pre-registration processes before the date of service across VAMCs.	Implement a standard pre-registration policy and process for all VAMCs.	Tier 2	Medium	People, Process, Technology
Training on Patient Intake procedures vary across VAMCs, and within VAMCs, inhibiting timely insurance identification.	Develop a formal training program managed by Patient Intake and Revenue Operations leadership.	Tier 2	Short	People, Process, Technology
VHA relies on costly back-end processes and outside contractors.	Continue current efforts to upgrade and further develop the eIV tool.	Tier 2	Medium	Technology
VA is unable to code outpatient encounters promptly, resulting in outpatient coding backlog across VHA and preventing accelerated billing and collections	Collaborate with OPM to streamline the process for sourcing, interviewing, and hiring new certified coders. Hire administrative staff members to support coders by performing non-coding functions.	Tier 2	Medium	People, Process

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
VHA provides inconsistent education on financial responsibilities to Veterans to help them understand their financial obligations.	Develop and implement a standard point-of-service collections policy.	Tier 2	Medium	People, Process, Technology
Collections are not maximized due to VHA's inability to collect ROIs from Veterans at the point-of-service.	Conduct mass mailing of VA Form 3288 (ROI form) to all Veterans currently enrolled to obtain Release of Information signatures.	Tier 2	Short	People, Process, Technology
<p>Legend</p> <p>Significance Tier 1 = Direct affect to payment and billing timeliness and accuracy Tier 2 = Supporting actions to improve payment and/or billing timeliness and accuracy</p> <p>Timeline Short Term=0-2 years, Medium=3-4 years, Long Term=>4 years</p> <p>Impacts People Process Technology</p>				

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

This page intentionally left blank.

7 Analysis of Non-VA Care Payments

7.1 Non-VA Care Introduction

The introduction section contains a description of the background of Non-VA Medical Care, hereafter referred to as “Non-VA Care,” legislative authorities, payment processes, and disbursement details and key findings related to Non-VA Care claim timeliness, accuracy, and interest payments. Additional detail regarding processes and detailed descriptions are included in the appendices following the main body of this report.

7.1.1 Non-VA Care – History

Non-VA Care, referred to as ‘Non Departmental’ care in the Veterans Choice Act, provides an option for eligible Veterans to seek care outside of VHA facilities. There are two broad categories of Non-VA Care: preauthorized care and emergent care. VHA approves preauthorized care prior to the Non-VA provider delivering care. VHA can approve preauthorized care for the following reasons:¹¹⁴

- VHA cannot provide the care
- VHA facility is not geographically accessible
- VHA facility cannot provide the service in a timely manner
- The Veteran cannot safely travel to VHA facility

Due to its nature, VHA conducts retrospective clinical and administrative reviews for emergent care to ensure it meets the requirements of the authority to purchase care outside of VHA facilities. Table 7-1, Types of Non-VA Care, outlines the types of Non-VA Care and eligibility requirements under the related care authority. Additional detail is located in Appendix 10A.2.2 Overview of Care Authorities. A separate assessment (Assessment C) examines Care Authorities in depth.

Table 7-1. Types of Non-VA Care

Type of care	Description and relevant payment authority	FY 2014 Spending Breakout ¹¹⁵
Preauthorized Care	Services with prior VHA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)	\$4,974,209,147

¹¹⁴ 38 Code of Federal Regulations (CFR) Section 17.53 – Limitations on use of public or private hospitals

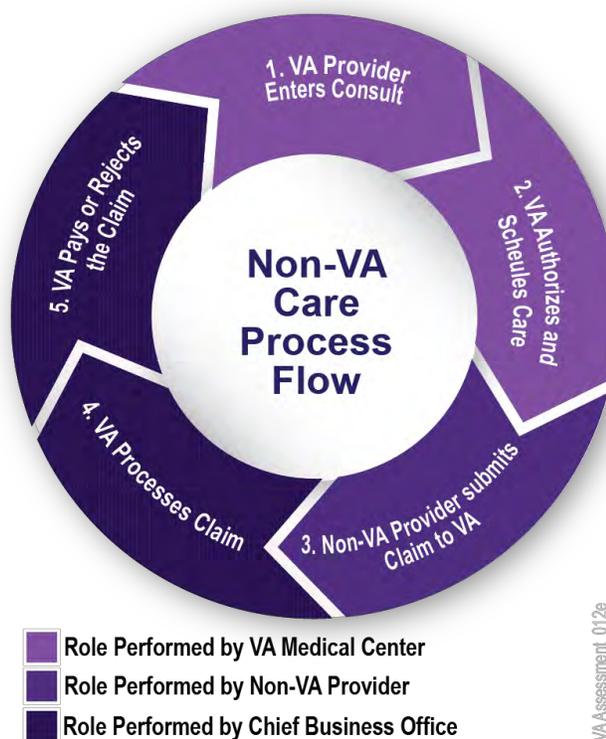
¹¹⁵ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

Assessment I (Business Processes)

Type of care	Description and relevant payment authority	FY 2014 Spending Breakout ¹¹⁵
Emergency care	Services without VHA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash). Includes emergency care for service-connected disabilities (38 USC 1728 – Unauthorized Care) and non-service connected care (38 USC 1725 – Mill Bill). Refer to Chapter 0 for more information regarding Veteran eligibility.	\$554,617,762

The process for authorizing care requires numerous steps by the local VAMC. Figure 7-1 illustrates the Non-VA Care Process.

Figure 7-1. Rendition of Non-VA Care Process Flow



Source: Grant Thornton rendition of Non-VA Care Process Flow based on CBO feedback.

1. Non-VA Care initiates when a VHA provider determines the Veteran requires or requests care outside of VHA. The VHA provider sends a request for a consult or referral to the VAMC authorization department. An authorization clerk reviews the request for Veteran eligibility, as defined in the care authorities in Table 7-1. Upon verifying the Veteran’s eligibility, the clerk generates an authorization and sends it forward for approval.

2. Either the chief of staff or the designated service line chief approves the request for care, after which the authorization clerk creates an official authorization guaranteeing payment for specific services and schedules an appointment a Non-VA Care provider.
3. The Non-VA Care provider sends an electronic or paper claim to VHA for processing and payment after rendering services.
4. Upon receipt, a VAMC claims clerk (CBO staff located at the VAMC) puts the claim through automated system and manual edits. Edits include, but are not limited to determination if the claim corresponds to the authorized services, or in the case of emergent services, eligibility and a host of other requirements outlined in detail in Assessment C. Emergent service claims also require documentation, which VHA clinicians review for medical necessity. Documentation is not required for review and payment of authorized care. Once the edits and reviews are complete, and the clinician determines everything is appropriate, they apply correct reimbursement rate and approves the claim for payment.
5. If the claim does not meet all requirements, the claim clerk denies payment, and a remittance is sent to the provider informing them of the reason for the denial.

Note, for extended emergent care the Non-VA Emergency Department is to notify VHA within 72 hours of patient admission so the VAMC may authorize retroactively and monitor treatment.

7.1.2 Non-VA Care—Current State

Non-VA Care experienced significant growth during the last decade. It has grown from a small, seldom-used alternative method of care to a multi-billion dollar program that supplements care provided at VHA facilities. CBO reports Non-VA Care claims have increased over 400 percent over the past 10 years and expenditures have increased from \$1.37 billion in FY 2004 to \$5.5 billion in FY 2014. Refer to Figure 7-2 for the spending trend lines. Over the same time, the number of unique Veterans treated through Non-VA Care increased 250 percent from 501,258 to 1,250,698.¹¹⁶ In 2014, this program processed over 14 million claims using FBCS. Because of the increase in need and legislative changes, VHA actions have been reactive, not proactive. Consequently, VHA has implemented short-term solutions for Non-VA Care processes, staffing, training, and technology.

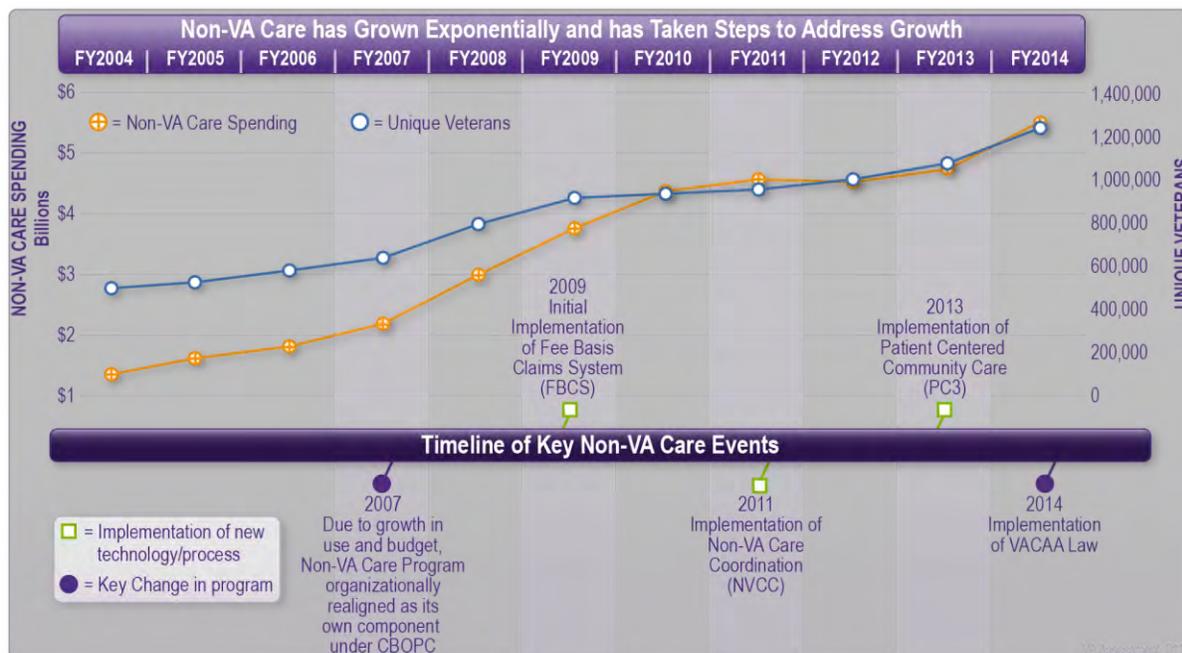
Over the past year, efforts to improve Veteran access to care have increased the utilization of Non-VA Care. In March 2014, 1.1 million claims were received; for the same month in 2015 the claim volume was approximately 1.6 million, a 45 percent increase.¹¹⁷ Initiatives to accelerate access to care through Non-VA care is forcing VHA to manage resources retroactively.¹¹⁸

¹¹⁶ National Academy of Public Administration (NAPA) VHA Fee Program White Paper, September 2011

¹¹⁷ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

¹¹⁸ Note: At the time of this report, VA had not prepared future projections of Non-VA Care spending.

Figure 7-2 Unique Veterans Served Compared to Total Non-VA Care Spending and Timelines of Key Non-VA Care Events¹¹⁹

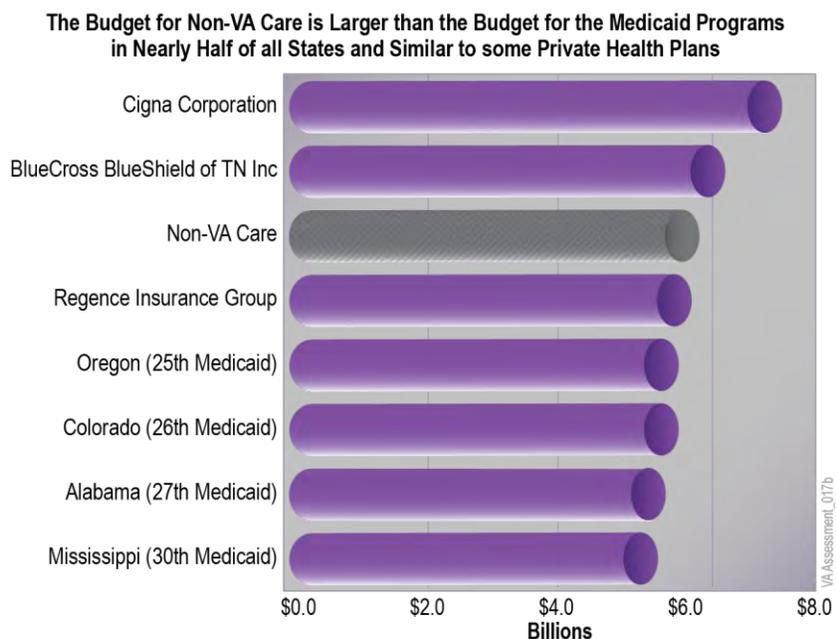


Source: Paid and Timeliness FY12-FY14 Data

At approximately \$5.5 billion in annual payments, Non-VA Care is comparable to a number of sizable commercial and federal health insurance programs and is larger than 23 of the 50 states’ Medicaid programs. In comparison, Medicare (excluding Part D) processes about \$365 billion annually through Medicare Administrative Contractors (MACs) using a decentralized, but highly standardized process. Figure 7-3 shows the Non-VA Care spending comparison.

¹¹⁹ Per Paid Data and Timeliness FY12–14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines.

Figure 7-3. Non-VA Care Spending Comparison^{120,121}



Source: Paid and Timeliness FY12-FY14 Data, Kaiser Family Foundation, and FY14 SNL Financial Data

The following sections provide an overview of new initiatives relevant to Non-VA Care. For more details on each program, refer to Assessment C.

Patient Centered Community Care (PC3)

Launched in 2013, Patient-Centered Community Care (PC3) contracts with vendors to develop a network of health care providers to deliver care to Veterans. Coverage includes primary, inpatient, outpatient, mental health, emergency (limited), newborn (limited in duration and female Veterans following delivery), and skilled home health care as well as home infusion therapy. Care is available through PC3 when local VHA Medical Centers cannot readily provide services, when demand exceeds capacity, geographic inaccessibility or other limiting factors.¹²²

To improve access to care, VHA contracted with HealthNet Federal Services (“HealthNet”) and TriWest Healthcare Alliance (“TriWest”) to expand their Non-VA provider network and administer the program. These PC3 vendors develop and manage their network of providers,

¹²⁰ Non-VA Care spending available per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics. State Medicaid spending data is available per Kaiser Family Foundation for FY13 - <http://kff.org/medicaid/state-indicator/total-medicaid-spending/>. The private-sector spending data for Cigna, BlueCross Blue Shield of TN, and Regence Insurance Group is available per SNL Financial for FY14.

¹²¹ Note: Non-VA Care spending does not include funding through Veterans Choice Act for the Choice Program.

¹²² Per Description PC3 on CBO’s website: <http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/index.asp#PC3>

coordinate care for the Veteran, and reimburse providers for care. 10A.2.7 and Assessment C provide additional background on PC3.

Effects of Veterans Access Choice and Accountability Act (VACAA) Legislation on Non-VA Care

Choice Program and Related Eligibility

Title I, Section 101 of the Veteran's Choice Act authorized the expansion of medical care through agreements with Non-VA entities.¹²³ The Choice Program allows Veterans to seek care in the community if the Veteran:

- Was unable to schedule any appointment with VHA for hospital care or medical services within VHA's "wait-time goals."
- Resides more than 40 miles from any VHA medical facility.
- Resides more than 20 miles from any VHA medical facility if his or her state of residency lacks a VHA medical facility providing hospital care, emergency services, or inpatient surgical care.
- Resides 40 miles or less from any VHA medical facility but either is required to travel by air or water to all VHA medical facilities within the 40-mile limit or is faced by an "unusual or excessive burden" in accessing those facilities due to "geographic challenges" as defined by VA (Sec. 101[b][2]).¹²⁴ Residing 40 miles or less from any VHA medical facility but is either required to travel by air or water to all VHA medical facilities within the 40-mile limit, or is faced by an "unusual or excessive burden" in accessing those facilities due to "geographic challenges" as defined by VA (Sec. 101[b][2]).

In addition, the law includes a \$10 billion fund for Non-VA Care as part of the Choice Program. The Choice Program is expected to operate for a period of three years or until allocated funds are exhausted. VHA expanded the scope of their contracts with HealthNet and TriWest to help administer the Choice Program.

VHA mailed Veterans thought to be potentially eligible for the Choice Program cards and a letter explaining the program; however, this led to confusion, as all Veterans were not immediately eligible.

Policies regarding third-party coverage also cause confusion for both providers and Veterans. Rules regarding primary and secondary payers and Veteran co-payments vary depending upon the basis of the Veteran's coverage (Choice versus Non-VA Care). Understanding the basis of eligibility (such as service connectedness) adds additional complexity. Assessment C, Authorities and Mechanisms for Purchased Care at the Department of Veterans Affairs, describes the

¹²³ Note: Eligible Veterans must have been enrolled in VA health care on or before August 1, 2014 and/or eligible to enroll as recently discharged combat Veteran within 5 years of separation in addition to meeting the standards described below.

¹²⁴ Assessment C, Authorities and Mechanisms for Purchased Care at the Department of Veterans Affairs.

ongoing changes to VA's authorities and mechanisms for purchasing care. Assessment C's team points out that the full landscape of VHA purchase care is complicated, and they highlight the drawbacks of a piecemeal approach absent a guiding orientation and strategy for VHA.¹²⁵

Transfer of Non-VA Care Payment Authority from VAMCs and VISNs to CBO

CBO Purchased Care manages the Non-VA Care Program, in addition to care for Veterans' dependents, Veterans overseas, and Veterans of Indian or Alaskan heritage. Prior to the Veterans Choice Act CBO did not have formal authority over operations at the VAMC. While CBO provided overall guidance to the field, each VAMC held responsibility for administering the Non-VA program. Section 106 of the Veterans Choice Act "[transferred] the authority to pay for hospital care, medical services, and other health care furnished through non-Department of Veterans Affairs providers from the VISN and medical centers of the Department of Veterans Affairs, to the CBO of the Veterans Health Administration of the Department of Veterans Affairs."¹²⁶

The implementation resulted in the consolidation of claims processing staff, and VHA initiated an assessment of roles and responsibilities to determine re-organization under CBO. This consolidation provides CBO with the authority to standardize processes and procedures to pay Non-VA claims, and enforce related rules and regulations across VAMCs nationally. The transfer of authority to CBO was a significant challenge due to a compressed schedule, and CBO continues to work through the transition.

Special Purpose Funding¹²⁷

In addition to consolidation of staffs, CBO now manages the Non-VA Care funds. Congress classifies these as 'special purpose' funds, meaning they cannot be used for other purposes. CBO obligates the funds and the VAMC records the obligation and accounts for the funding.

Prior to the implementation of the Veterans Choice Act, Non-VA Care funds were general purpose and included in the VAMCs' operating budget.¹²⁸ The VAMCs flexibility to shift funds is limited as a result of the special purpose funding. For example, if Non-VA Care authorizations decrease the VAMC no longer has the ability to direct funds towards other patient care initiatives.¹²⁹

VAMCs continue to be the primary source of Veteran care. When VAMC care is not feasible or accessible VHA providers are required to seek care at other government medical facilities prior to seeking care to the private sector. As shown in Figure 7-4, VA has defined a hierarchy for care.

¹²⁵ Assessment C, Authorities and Mechanisms for Purchased Care at the Department of Veterans Affairs.

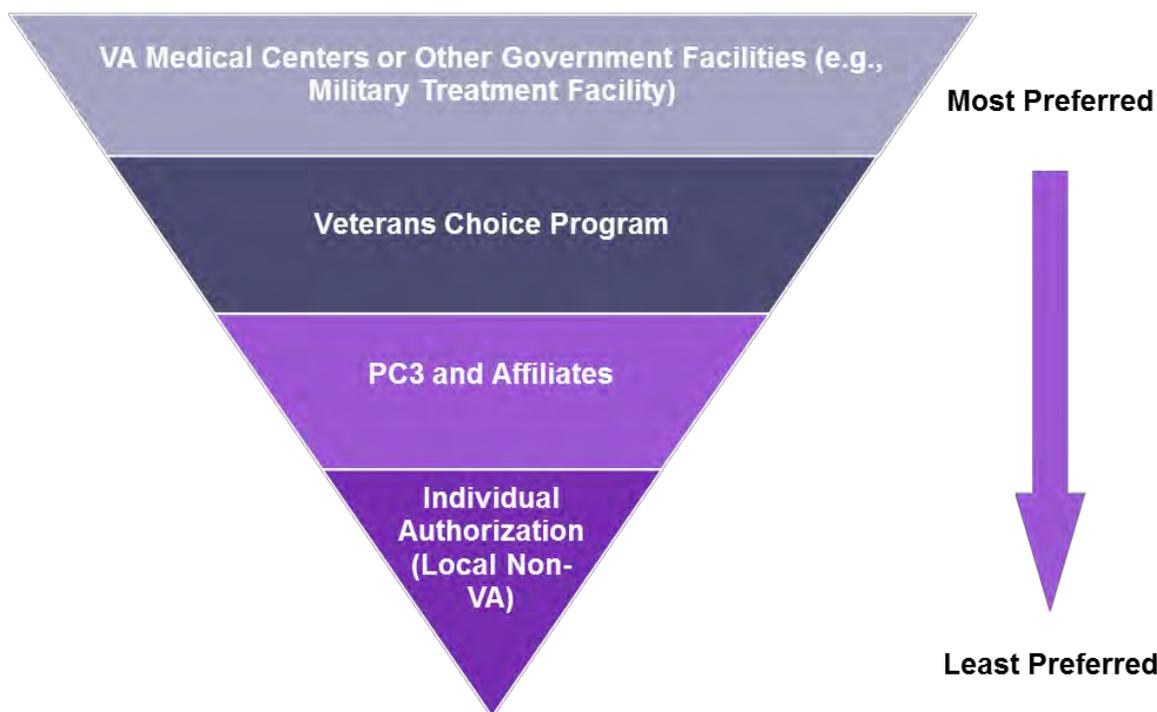
¹²⁶ Veterans Access, Choice, and Accountability Act of 2014

¹²⁷ Note: Further analysis of the Non-VA Care funding mechanisms was out of scope of this assessment.

¹²⁸ Qualitative Interviews with four VAMCs (Salt Lake City, Philadelphia, San Francisco, and San Antonio)

¹²⁹ Qualitative Interview with one VAMC (Salt Lake City)

Figure 7-4. Designated Sequence Order for Obtaining Care through VHA¹³⁰



Source: Grant Thornton’s rendition of VHA’s designated sequence order for care based on qualitative interview

VHA has a long-standing collaborative relationship with the U.S. Department of Defense (DoD) to provide health care services to Veterans. Under a resource sharing arrangement between VA and DoD, Veterans may receive purchased care services at a DoD facility. In their report, Assessment C states in FY 2013 DoD purchased \$152 million in services from VHA; and DoD provided \$119 million in medical resources to VHA. While referrals to DoD facilities and providers are preferred, the location and security requirements of DoD installations limit the ability to refer Veterans to them. (See Assessment C for a detailed description of the VHA’s arrangement with DoD and other government agencies.)

PC3 is the preferred method of contracting for care in the private sector. VHA centralized contract administration of the PC3 program with the intent to replace their local provider contracts. VISN and VAMC leadership is encouraged not to renew or establish local provider contracts outside of PC3. Each VAMC uses this hierarchy of care to prioritize treatment options.

7.2 Non-VA Care Assessment Approach

7.2.1 Data Sources and Analysis

As described in the methodology of this report (Chapter 2), our approach consisted of information collection and analysis. We collected a variety of qualitative and quantitative data that directed our findings and recommendations. This data includes: (1) payment timeliness

¹³⁰ Qualitative Interview with CBO Purchased Care Leadership in Denver, CO.

and accuracy data, (2) interest penalties data, (3) staffing and productivity data, and (4) IT systems data. Additional data sources include interviews with more than 44 Non-VA Care staff members as well as several executive interviews with VHA leadership.

7.2.2 Past Findings and Recommendations

A key part of our approach was the review of the findings and recommendations outlined in prior assessment reports. Previous reports, including VA OIG, White Papers, and Improper Payment Elimination and Recovery Improvement Act Reports, have identified weaknesses in VA’s control and oversight of payments made to Non-VA entities. Our team has outlined a sample of key findings from these assessments in Table 7-2. Note that these examples illustrate the type of factors identified in recent years, and are not intended to be a comprehensive listing.

Table 7-2. Previous Non-VA Care Report Findings

Process Area	Cited Findings	2009	2010	2011	2012	2013	2014	2015
Technology	Little automation of systems affect efficiency and accuracy			White Paper				
	A centralized claims processing system will improve payment accuracy and processing timeliness						VA	
	Inefficiencies due to the fee program's decentralized structure and labor intensive payment system		OIG					
	Inefficient fee program leading to error rates than benchmarked organizations		OIG					

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Process Area	Cited Findings	2009	2010	2011	2012	2013	2014	2015
	Manual data input and decentralized structure						VA	
	Manual nature of claims processing, decentralized structure of claims processing operations				IPERIA	IPERIA	IPERIA	
Process	IPERIA ¹³¹ reported a 27.18 percent of all improper payments were attributed to clerks selecting the wrong payment schedule						IPERIA	
	Lack of clear oversight responsibilities and procedures	OIG						
People	Lack of comprehensive policies and procedures, and identified core competencies	OIG						
	Failure to define roles, responsibilities, and processes was contributing factor to organizational failure							VA ¹³²

¹³¹ Improper Payment Elimination and Recovery Improvement Act (IPERIA)

¹³² VHA (2015) Task Force on Improving Effectiveness of VHA Governance, Report to the VHA under Secretary for Health

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Process Area	Cited Findings	2009	2010	2011	2012	2013	2014	2015
	Mandatory training requirements for fee staff	VA						

7.3 VHA Does Not Have Adequate Infrastructure and Streamlined Processes to Pay Non-VA Care Claims Timely and Accurately.

As mandated in Section 201 of the Veterans Choice Act, our review focused on the timeliness, accuracy, and associated interest penalties of payments to Non-VA Care providers. The following sections describe high-level findings related to these processes.

7.3.1 Timeliness – Issues with Paying Claims Timely Exists throughout VHA

The inability to pay Non-VA Care claims timely results in a multitude of issues. Paying claims in a timely fashion is essential to attracting and retaining the community-based providers necessary to augment VA Care.

Prompt claim payment is also essential to the coordination and quality management of Veterans’ health care. Most Veterans accessing Non-VA Care also receive care at VHA facilities; thus, a Veteran gets better care if VHA providers are knowledgeable about the Non-VA services the Veteran received. As Non-VA providers generally submit medical documentation with or as follow-up to their claims, this information is generally available.

Late claims payment creates liability for VHA. With Non-VA Care growing as a percentage of the total VHA budget, tracking Non-VA Care claims liabilities, including interest payments, will be increasingly important.

According to VHA policy, “90 percent of all Non-VA health care claims are processed within 30 days of the date the claim is received by the facility.”¹³³ Our analysis shows VHA is processing approximately 70 percent of claims within 30 days, 20 percent below VHA claims payment timeliness standards. Further examination of claims payment timeliness reveals on average VHA is paying claims within 34.2 days; however, this statistic does not reflect the underlying significant variation in claims payment timeliness. With VHA’s high claim volume, even a small percentage of late claims payment translates to hundreds of thousands of claims at any given point in time. Not only does this create interest penalties, it also stresses relations with the provider community, and draws negative attention that overshadows overall performance. For example, in recent testimony by Vince Leist, a representative for the American Hospital Association, before the House Subcommittee on Health for Veterans Affairs on June 3, 2015,

¹³³ VHA Directive 2010-005 – Timeliness Standards for Processing Non-VA Provider Claims.

Assessment I (Business Processes)

Mr. Leist described that VHA has yet to pay an Arkansas medical center for 215 claims totaling more than \$750,000 and dating back to 2011.¹³⁴

As revealed by Table 7-3, in FY 2014, VHA paid 20.7 percent of claims 35 days or more after receipt.¹³⁵

Table 7-3. Percent of Claims Line Items Paid by Number of Days After Receipt, FY2012 through FY2014¹³⁶

Days											
Fiscal Year	5	10	15	20	25	30	35	40	45	60	90
FY12	0.6%	1.3%	2.2%	2.9%	33.7%	67.1%	73.4%	77.8%	81.5%	88.1%	93.9%
FY13	1.0%	1.4%	2.8%	3.8%	34.6%	69.4%	77.0%	81.6%	85.8%	92.3%	97.3%
FY14	0.7%	1.1%	2.5%	3.7%	35.9%	70.3%	79.3%	84.0%	87.3%	92.5%	96.8%

Source: Paid and Timeliness FY12-FY14 Data

When evaluating Non-VA Care claims payment timeliness, several factors must be considered:

- VA money management policy slows claims payment and affects VHA’s timeliness metrics. According to CBO, VHA holds payment of processed claims 25 days from date of receipt.¹³⁷ Table 7-3 identifies the percentage of claim lines paid by number of days for FY 2012 through FY 2014 and illustrates that VHA pays very few claim lines within 20 days of receipt.
- VHA date stamp policy results in miscalculation of processing timeframes for Non-VA Care claims. VHA policy states, “All claims should be date stamped with the date the claim is received at the facility and in those instances when the date of claim is unknown, the postmark date or date of invoice, whichever is later, should be used as the receipt date.”¹³⁸ Effectively, when counting days to process a claim, the date of receipt “starts the clock” and the date the claim is approved for payment or returned to the Non-VA provider “stops the clock.” When VHA returns the claim to the Non-VA provider for additional information or corrections, the clock resets to zero.
- According to interviews, due to inadequate staff and increased claims volume, VHA has experienced backlogs in scanning paper claims into FBCS. This creates the risk of an

¹³⁴ Testimony of Vince Leist on behalf of the American Hospital Association before the Subcommittee on Health of the Committee on Veterans’ Affairs – June 3, 2015

¹³⁵ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

¹³⁶ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

¹³⁷ Qualitative Interview with VA’s Financial Services Center (FSC). The FSC is responsible for finalizing and releasing payment to Treasury.

¹³⁸ VHA Directive 2010-005, Timeliness Standard for processing Non-VA provider claims

inaccurate receipt date, or possibly losing the claim. If a claim is not date stamped or scanned when received, VHA will not capture the true date of receipt with a subsequent inaccurate calculation of claims timeliness. To mitigate some of these risks, CBO implemented a daily certification in late 2014 that requires VAMCs to acknowledge having scanned all claims received that day into FBCS.

- Non-VA Care’s timeliness standard for “clean” claim payment is not comparable to industry practice.¹³⁹ Per CMS, a “clean” claim is one that does not require the carrier to investigate or develop external to their Medicare operation on a prepayment basis.” We note that the industry timeliness benchmark is for clean claims. Since VHA measures timeliness for all claims and not for clean claims,¹⁴⁰ the industry benchmark is not directly relatable to VHA; however, we have included it in Appendix D-1 as a point of reference.¹⁴¹

To better understand the variation in claims payment timeliness, we analyzed the status of in-process¹⁴² claims (i.e., claims that VHA has received and entered into the claims processing system but has not yet finished processing) as of February 27, 2015. Our analysis measured the number and percentage of claims and days outstanding; claim value was not available. This examination revealed nearly 70 percent of claims entered the system within 30 days of receipt and had potential to be paid timely. Notably, we presume the remaining claims will be paid late.

As illustrated in Table 7-4, approximately:

- 16 percent of claims were 31-60 days old.
- 13 percent of claims were 61-180 days old.
- 1 percent of claims were more than 180 days old.

Notably, approximately 25 percent of claims are delinquent 31 to 120 days and require targeted focus.

¹³⁹ Medicare Claims Processing Manual Chapter 1 - General Billing Requirements, section 80.2

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>.

- “[Clean claims] have all basic information necessary to adjudicate the claim, and all required supporting documentation”

- Clean claims do “not require external development (i.e., are investigated within the claims, medical review, or payment office without the need to contact the provider, the beneficiary, or other outside source)”

¹⁴⁰ Qualitative Interview with CBO Purchased Care Operations Directorate

¹⁴¹ Note: The calculation of claims timeliness rates: Most commercial benchmarks use in the denominator a count of clean claims only; they do not count in the denominator claims that were incomplete or submitted with invalid values, known as “dirty” claims. VA, in contrast, may not distinguish between clean and “dirty” claims when counting claims for the denominator. Counting clean and “dirty” claims in the denominator inflates the denominator and could explain in part why VA’s claims processing timeliness rates are low relative to commercial benchmarks.

¹⁴² Note: Non-VA Care refers to these claims as “Pending Claims.” Industry uses the term “pending claims” to refer to claims that have been suspended due to the need for additional information from an external source such as the health care provider, facility or the member.

Assessment I (Business Processes)

The skewed distribution of this claims aging report shows how over 30 percent of providers experience delays in payment and VHA is well below its claims payment timeliness performance standard of paying 90 percent of claims within 30 days.

Table 7-4. Number and Distribution of Non-VA Care Claims In-Process as of February 27, 2015^{143,144}

Days Since Receipt of Claim	Number of Claims	Percent of Claims
0-30 days	1,045,044	69.94%
31-60 days	239,740	16.04%
61-90 days	106,284	7.11%
91 to 120 days	52,340	3.50%
121 to 150 days	26,876	1.80%
151 to 180 days	10,944	0.73%
181 to 210 days	5,967	0.40%
211 to 240 days	2,516	0.17%
241 to 270 days	1,544	0.10%
271 to 300 days	620	0.04%
301 to 330 days	540	0.04%
331 to 365 days	382	0.03%
More than 365 days	1,376	0.09%
All Claims In Process	1,494,173	100.00%

VHA must consider timeliness in the context of payment accuracy, discussed further in the next section. Unless the underlying infrastructure, technology and process complexities issues are addressed, risks are high that the timeliness and accuracy issues will grow and become even more widespread. Additional analysis related to VHA timeliness of non-VA Care payments is located in the Appendix, Section A.2.3.

¹⁴³ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

¹⁴⁴ Note: CBO could not readily provide the dollar values associated with these claims. CBO indicated they could provide the billed amount, but this is not reflective of amount VA pays to the Non-VA provider. As previously stated the high dollar amount would demonstrate the point above – while the percent is low, the number [and value] of the claims is high.

Table 7-5. VHA Timeliness: Percentage of Claims Processed within 30 days

	VHA Performance: Timeliness ¹⁴⁵ All Claims	VHA Performance Standard ¹⁴⁶ All Claims	Commercial or Other Payer Benchmark ¹⁴⁷ “Clean” Claims
2012	66.9%	90%	96%
2013	69.3%	90%	96%
2014	70.2%	90%	96%
Note: The commercial benchmark uses “clean claims,” (i.e., claims that do not require additional documentation from the Non-VA provider. VHA’s benchmark uses all claims and VHA cannot track clean claims; therefore, VHA is unable to generate claims payment timeliness statistics in the same manner as industry).			

7.3.2 Accuracy – VHA Payment Accuracy is Lower than Private-Sector Benchmarks.

Only six of 21 VISNs met VHA standard and the industry standard benchmark for payment accuracy. Since 2009, VHA improvements have increased accuracy rates from 83 percent to 91 percent in 2014; however, that is still lower than the VHA standard of 98.5 percent.¹⁴⁸

Paying claims accurately is essential to VHA’s financial management, in addition to disciplined stewardship of taxpayer dollars. Overpayments result in unnecessary expenditures; whereas underpayments could result in unanticipated claims liabilities and higher administrative costs associated with payment adjustments.

In addition, inaccurate payments further hinder relationships with Non-VA providers, requiring the provider to spend, for example, time on the phone with provider services staff tracking claims status and correcting and resubmitting claims. Frustrated community-based providers may not be willing to treat Veterans if issues persist.

Accuracy rates were calculated as part of the Improper Payment Elimination and Recovery Improvement Act (IPERIA) reports based upon the rate of inaccurate payments on a statistically valid sample.¹⁴⁹ Our team compared the accuracy of Non-VA Care claims payment to commercial health care industry standards and practices and to IPERIA performance standards. We summarize VHA’s performance in claims payment accuracy in Table 7-6.

¹⁴⁵ “Timeliness” rate derived from Informatics team email: “RE: Data Request and discussion regarding denial data” on 3/4/2015: Accuracy as % of paid = “Claims < 30 days” / “Total claims”

¹⁴⁶ VHA Directive 2010-005, Timeliness Standard for processing Non-VA provider claims

¹⁴⁷ RSM McGladrey 2013 Report of Lead Regulators, UnitedHealthcare

¹⁴⁸ FY 2009 VA Performance and Accountability Report (PAR): <http://www.va.gov/budget/report/>

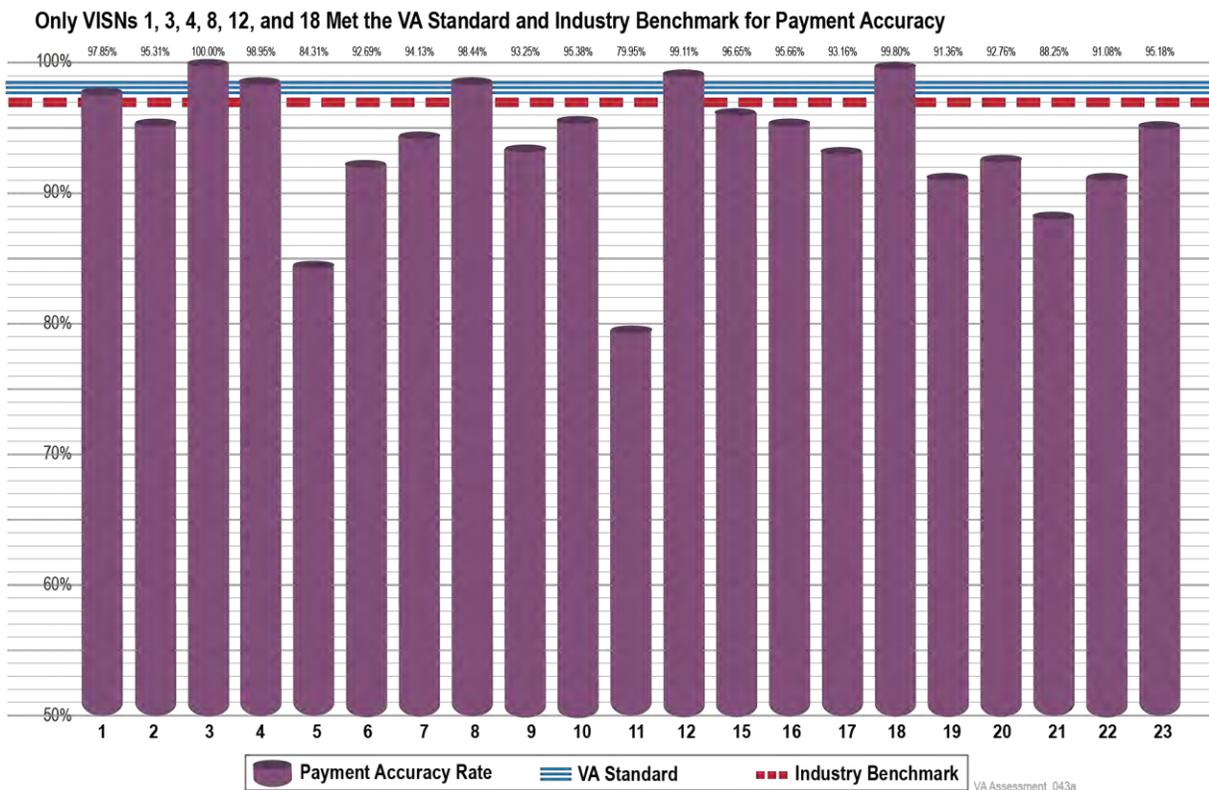
¹⁴⁹ FY 2014 Improper Payment Elimination and Recovery Improvement Act Report identifies a listing of events categorized as inaccuracies.

Assessment I (Business Processes)

Table 7-6. VHA Accuracy of Payment

FY	VHA Payment Accuracy ¹⁵⁰	VHA Performance Standard	Commercial or Other Payer Benchmark ¹⁵¹
2012	88.0%	98.5%	97%
2013	90.35%	98.5%	97%
2014	90.76%	98.5%	97%

Figure 7-5. Payment Accuracy Rate by VISN¹⁵²



Source: FY2014 IPERIA Data

VHA’s low rate of payment accuracy is attributable to the high degree of manual intervention required to process a claim. Currently, VHA does not have the capability to “auto-adjudicate” a claim, meaning VHA staff are required to make complex decisions regarding eligibility and

¹⁵⁰ Accuracy (IPERIA Reports 2012-2014) claims payment processing compliance with established VA pricing and payment methodologies, policies, handbooks, and regulations.

¹⁵¹ RSM McGladrey 2013 Report of Lead Regulators, UnitedHealthcare

¹⁵² Per Request-Accuracy.xlsx. This workbook includes FY2014 IPERIA data for each sample reviewed. To arrive at these figures from the raw IPERIA testing data, the team divided the sum of the improper payment amount by the sum of the amount sampled/paid for each VISN.

pricing. Furthermore, VHA staff members make these decisions without comprehensive and standardized procedures guides.¹⁵³ Refer to sections 7.6 and 8.4 for more information regarding the root-causes of payment errors.

To ensure accuracy of claims payment, one VAMC within VISN 8 conducts extensive pre-authorization and pre-payment reviews of each claim, resulting in an FY2014 error rate of less than one percent.¹⁵⁴ While this is a best practice, these reviews require Non-VA Care program subject matter expertise and they may not be repeatable at all VAMCs. A comprehensive training program for supervisors would increase the likelihood of successful implementation at other VAMCs.

On March 2, 2015, VA's Inspector General reported as of August 2014, VHA had spent \$73.8 million of the \$92.8 million required to develop and implement a new processing system to correct many of these issues. Work ceased upon discovery that incorrect funding appropriations were allocated for this procurement. The report indicates VHA established a target date of June 30, 2015 for correcting the appropriations issue.¹⁵⁵ The outcome of this was not available at the time of publishing.

7.3.3 Findings and Recommendations for Timeliness and Accuracy

The processes and effective execution of key activities, both from timeliness and accuracy perspectives, are essential to maintaining the network of providers necessary to keep America's health care promise to our Veterans. The infrastructure part of this finding includes the lack of documented guidelines and procedures, inadequate technology and tools, and insufficiently trained and inadequate number of staff coupled with the highly complex, and inconsistent rules spread across VHA and outlined in Assessment C.

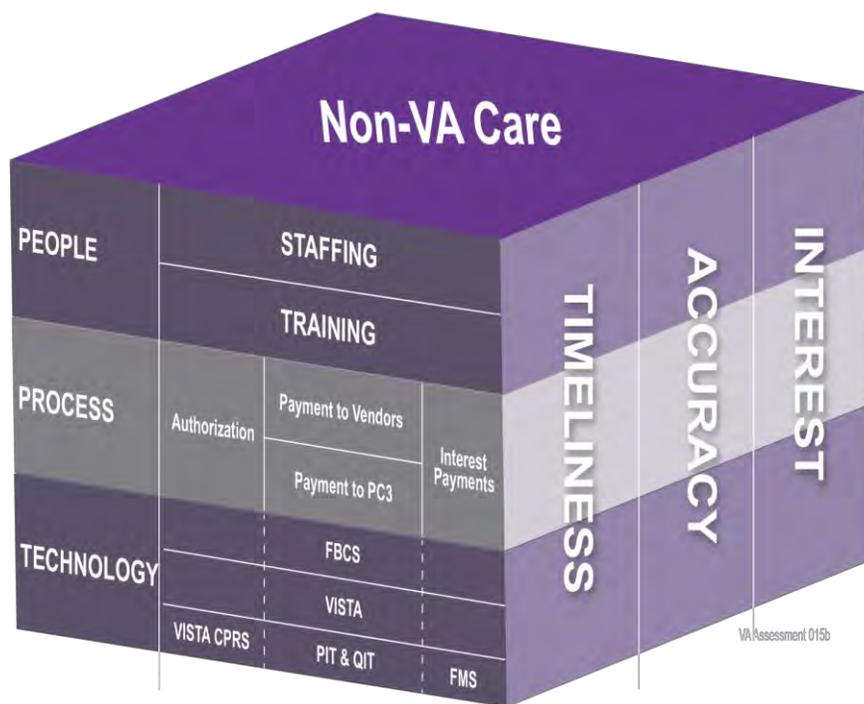
The following section discusses root causes and major sub-findings that contribute to this overarching finding, as well as our recommendations for improvement to timeliness, accuracy, and penalties discussed above. The drivers of Non-VA claims payment performance on timeliness, accuracy, and interest payments are people, process, and technology, as illustrated in Figure 7-6. The following section discusses people and process findings and recommendations. Chapter 8 discusses Non-VA Care technology.

¹⁵³ FY 2014 Improper Payment Elimination and Recovery Improvement Act Report identifies a listing of events categorized as inaccuracies. Per Interviews with CBO Business Systems Management Directorate and four VAMCs.

¹⁵⁴ Ibid.

¹⁵⁵ OIG Report 14-00730-126, Reviewed of Alleged Misuse of VA Funds to Develop the Health Care Claims Processing System, March 2015

Figure 7-6. People, Process, and Technology Tied to Timeliness, Accuracy, and Interest Payments



Source: Grant Thornton’s rendition of VHA’s people, process, and technology component for Non-VA Care

Non-VA Care procedures for processing claims are complex, often confusing, and lead to the inaccurate and untimely claims payments. Assessment C provides detailed information on the complexities of care authorities. Unlike the insurance industry Non-VA claims processing staff must manually determine eligibility, interpret authorities (benefits), apply the correct payment rate, and interpret system edits. The authorities governing Non-VA Care and service connected disability determination require careful interpretation and are difficult to translate from requirements to operations. We organize our findings and recommendations for timeliness and accuracy into the sections below:

- 7.3.4 Claims Submission Requirements
- 7.3.5 Process for Authorizing Non-VA Care
- 7.3.6 Patient Centered Community Care (PC3)
- 7.3.7 Preventing Inaccurate Payments.

7.3.4 Claims Submission Requirements

In the typical provider and a payer transaction, payers are responsible for furnishing guidance on claims submission requirements. This includes specialized instructions for unique rules relevant to the payer. Private-sector payers typically develop a Provider Manual (often referred to in the industry as an 837 companion guide) to describe detailed instructions on how to submit claims for reimbursement. These manuals are often hundreds of pages, available online

with search capabilities, and address comprehensive and detailed requirements and billing scenarios.¹⁵⁶

Findings

1. Inadequate Non-VA Care Claims Submission Guidance Contributes to Increased Workload and Payment Errors.

- Non-VA providers lack access to VHA’s detailed billing, authorization and clinical documentation requirements, leading to increased workload for VHA staff and Non-VA staff, and inadvertent duplicate billing and payment. Lack of provider education increases the risk of erroneously billed claims and affects claims backlogs as the Non-VA providers resubmit for unpaid services. VHA does not publish a provider or a billing manual. If a provider inquires about instructions to bill VHA staff typically recommend following Medicare guidance, which is not completely applicable to Non-VA Care. CBO understands the need to create a provider and billing manual, however a manual is not in development and we were unable to determine a date for publishing one.
- Non-VA providers are directed to CBO’s website which includes a link to the VHA Provider Guide, an overview of how to work with VHA.¹⁵⁷ While the VHA Provider Guide documents high-level instructions to bill VHA, it does not provide billing instructions related to the multitude of scenarios and requirements facing Non-VA providers. We asked Non-VA Care supervisors for the guidance given to providers, and they referenced the VHA Provider Guide. The Provider Guide instructs providers to bill based on Medicare requirements; however, there are some critical differences between VHA and Medicare, specifically regarding eligibility and documentation requirements.

Table 7-7. Examples of Billing Differences between VHA and Medicare

Type of Claim	Medicare Policy	VHA Policy
Dental Claims	“Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. Medicare Part A (Hospital Insurance) will pay for certain dental services that you get when you are in a hospital. Part A can pay for inpatient hospital care if you need to have emergency or complicated dental procedures, even though the dental care is not covered.” ¹⁵⁸	VHA pays service-connected dental claims.

¹⁵⁶ Peter Kongstvedt “Essentials of Managed Care” Fifth Edition, 2007 Pg 393.

¹⁵⁷ Working with Veterans Health Administration: A Guide for Providers - http://www.va.gov/PURCHASEDCARE/docs/pubfiles/programguides/NVC_Providers_Guide.pdf

¹⁵⁸ Medicare Dental Information <http://www.medicare.gov/coverage/dental-services.html>

Assessment I (Business Processes)

Type of Claim	Medicare Policy	VHA Policy
Maternity Claims	Most people on Medicare are age 65 and older so the program is not usually associated with childbearing. As a result, Medicare guidance for maternity related claims is minimal.	VHA will reimburse for maternity care.

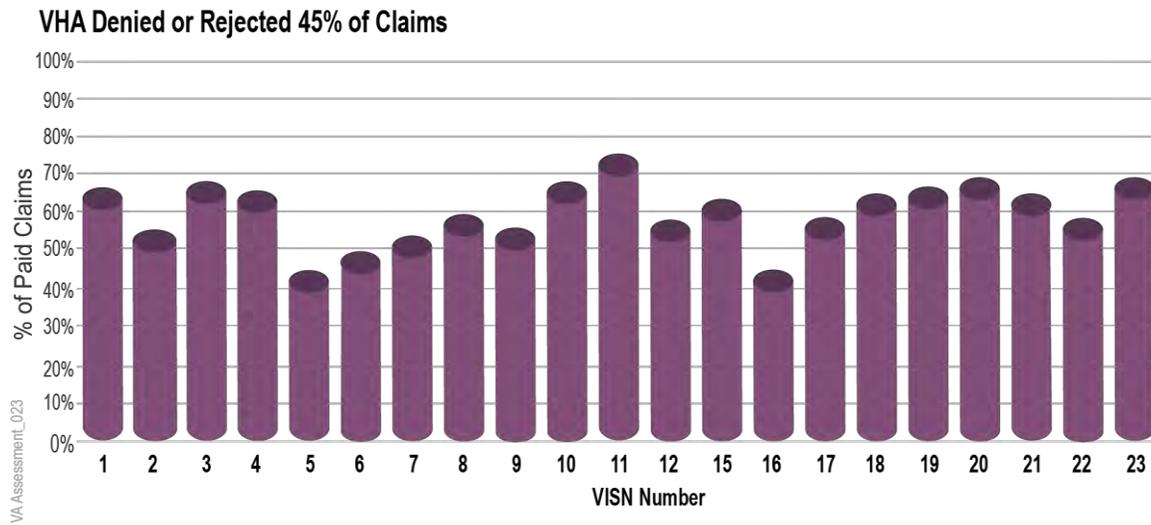
- Lack of provider education increases the risk of erroneously billed claims, resulting in claims backlogs as the Non-VA providers resubmit for unpaid services. Multiple VAMCs indicated that some Non-VA providers periodically resubmit the claims until VHA pays.¹⁵⁹ This adds to the backlog of claims, increases processing time, and the risk of paying for the same services twice. According to paid and denial data provided by CBO, VHA paid 54.1 percent of submitted claims in calendar year 2014, meaning 45.9 percent of claims were returned to Non-VHA providers to correct an error on the claim.¹⁶⁰ One Non-VA provider’s billing staff indicated that VHA denies 58 percent of that Non-VA provider’s claims.¹⁶¹ Figure 7-7 shows the percentage of submitted Non-VA Care claims paid by each VISN.

¹⁵⁹ Note: VHA currently does not have a standard for the percentage of claims (or claim lines) that should pay. The commercial benchmark cited here is for professional claim (i.e., CMS-1500 claims submitted by medical practitioners) lines, whereas VHA’s performance is based on all claims (i.e., professional, facility, dental and pharmacy claims). We could not directly compare VA’s performance to the commercial benchmark because of limitation in the data available.

¹⁶⁰ Per CBO File “Paid Denied or Rejected data thru 4-30-15.xlsx”. See previous discussion on performance compared to commercial benchmark.

¹⁶¹ Qualitative Interview with Non-VA provider billing staff in Salt Lake City, Utah

Figure 7-7. CY 2014 Percentage of Submitted Claims Paid^{162,163}



Source: CY14 Paid, Denied, or Rejected Data

- Policies regarding third-party coverage have also caused confusion for both providers and Veterans.¹⁶⁴ Rules regarding primary and secondary payers and co-payments vary depending upon the basis of the Veteran’s coverage (Choice versus Non-VA Care, for example) and understanding the basis of eligibility (such as service connectedness) adds further confusion.
- Duplicate claims unnecessarily increase volume and workload for Non-VA Care staff and exacerbate VHA claims payment timeliness issues. Non-VA Care providers submit duplicate claims because they:¹⁶⁵
 - Cannot determine the status of a claim
 - Are not paid on time
 - Are instructed to submit the claim to the VAMC closest to the Veteran’s home Zip Code regardless of which VAMC is responsible for processing that claim
 - Resend claims when they submit medical record documentation to support the original claim.

2. Policy complexity for Staff and Non-VA Providers Results in a High Risk of Improper Payments and Causes Confusion, Inefficiencies, and Errors in a Manual Environment.

¹⁶² Per CBO File “Paid Denied or Rejected data thru 4-30-15.xlsx”. See previous discussion on performance compared to commercial benchmark.

¹⁶³ Note: Paid, denied, and rejected claims were not tracked for the entirety of FY 2014; therefore, CY 2014 was the only full year of data available.

¹⁶⁴ Per Interviews with four VAMCs and two Non-VA provider billing staffs

¹⁶⁵ Ibid.

Assessment I (Business Processes)

- Complex rules and disparate processes result in inconsistencies in authorization and payment practices. Without standardized processes and procedures claims clerks conduct complex assessments inconsistently across VAMCs, potentially leading to inaccurate payment. Unclear authorizations lead to confusion among Non-VA providers and potential payment for unauthorized services.
- According to the 2014 IPERIA report, 27.2 percent of all improper Non-VA Care payments were the result of claims clerks selecting the wrong payment schedule. The second highest cause of improper payment was incorrect assessments regarding Veteran eligibility) 10.7 percent). The third highest case of improper payment was selection of the wrong care authority at 7.8 percent.¹⁶⁶ In addition, claims clerks have to interpret, and in many cases override, complex system edits without any point of reference, such as a procedure guide due to system limitations. One site developed a local “cheat sheet” to help guide the claims clerk through these scenarios.
- A 2009 OIG report on VHA’s patient fee care program states “VHA does not have a centralized source of comprehensive, clearly written, current policies and procedures for the [Non-VA Care Program]. Instead, Non-VA Care supervisors and staff rely on an assortment of resources that contain some policy, technical guides for the VistA Fee system, training materials, and informal guidance, such as conference call minutes.”¹⁶⁷ Since the 2009 OIG audit, VHA reported all recommendations and proposed actions were completed. However, we observed VHA continues to struggle with these challenges, indicating lack of sustainability in changes implemented. The recent transfer of responsibility to CBO under the Veterans Choice Act provides an excellent opportunity for VHA to develop and successfully implement standardized processes and procedures.
- The lack of standardized processes and procedures prohibits VHA from developing consistent keystroke-level training on a national scale. While there is general, high-level training and guidance to help the claims clerk understand Non-VA Care, there is no detailed training to instruct the claims clerk on how to process and pay claims. Every location, whether a local VAMC or consolidated VISN payment center, processes claims with slight variations; therefore, every location has unique training needs. The best practice is to have detailed and standardized internal processes and procedures.¹⁶⁸
- VHA cannot establish productivity standards and monitor employee performance because its processes are not consistent across VAMCs and VISNs. For example, some VAMCs appear to have the claims clerks work closely with the authorization personnel and involved in care coordination, while others do not. Some claims clerks are more involved in “provider relations” activities than others. Additionally, claims clerks work on all types

¹⁶⁶ FY 2014 IPERA Report (Final) Pg. 6

¹⁶⁷ OIG Audit of Veteran’s Health Administration’s Non-VA Care Outpatient Fee Program, Report No. 08-02901-185, August 3, 2009

¹⁶⁸ Essentials of Managed Health Care, Fifth Edition By Peter Reid Kongstvedt Page 413 “Discreet policies and procedures are required for all claims capability tasks...They should be thorough in that they account for every single step in a process. Thoroughly reviewing and documenting processes helps to reveal inconsistencies or gaps in claims processes that compromise quality and/or efficiency”

of claims that require varying levels of effort. Some claims clerks process only authorized claims while others work both authorized and unauthorized. In some cases, even outpatient and inpatient claims are divided among claims staff.

- Inconsistencies extend beyond processes and procedures to department naming conventions. From facility to facility, departments with the same operational responsibilities often have varying names and position descriptions, leading to Non-VA provider confusion. For example, four VAMCs referred to the authorization and scheduling department for Non-VA Care by four different names: Patient Administration Services (PAS), Health Administration Services (HAS), Business Service, and Non-VA Care Coordination.
- Adding to the complexities that characterize traditional Non-VA Care, VHA staff now struggle to understand new Patient Centered Community Care (PC3) and Choice Program requirements. Although the same vendors operate PC3 and Choice, the procedures and related legislative requirements are inconsistent across these two programs. For example, VHA creates the authorization for PC3-related care, whereas HealthNet or TriWest creates the authorization for Veterans Choice Program-related care. These nuances create confusion for VHA staff, vendors and Non-VA providers, leading to risk of untimely and/or inaccurate payment.
- VHA has not updated official Non-VA Care employee handbooks since 2008, and the best practice is to update the official handbooks continuously.¹⁶⁹ CBO officials indicated they are in the process of creating standardized processes and procedures, but the extensive vetting process of draft guidance (e.g., reviews by General Counsel, CBO, and Program Offices delays the issuance of any guidance). To mitigate the lack of updated handbooks, CBO developed operational plans and procedures, which do not require the same degree of vetting; however, CBO does not enforce these plans and procedures. Ultimately, the lack of clear direction, at a national level, leaves individual facilities to develop their own, individualized processes.

Recommendations

To address these findings, CBO should:

- Develop a comprehensive online Provider Guide (that includes an 837 companion guide and billing manual) to offer Non-VA Care providers detailed instructions about how to bill VHA. Doing so will reduce duplicates, rejections, inquiries, administrative burden on Non-VHA providers, and increase timeliness and accuracy of payment. When a claim is submitted correctly the first time, the claims clerk can spend more time processing payments instead of following up with Non-VA Care providers. Non-VA Care provider billing manuals will ultimately lead to better relations with Non-VA providers.

¹⁶⁹ Peter Kongstvedt “Essentials of Managed Care” Fifth Edition, 2007 Pg 413 “One cannot overstate the value of thorough, well-written, cross-functional, current, and accessible policies and procedures”

- Create a provider portal so that providers can routinely check the status of submitted claims.
- Create a centralized call center with dedicated staff to answer Non-VA provider questions. The frequency and purpose of the calls, as well as the call notes and outcomes, should be available across VHA so that claims clerks, supervisors, and authorization staff can access that information if they need to. Creating a centralized call center will allow claims clerks to focus more time on the processing and payment of claims, leading to improved timeliness and accuracy.¹⁷⁰
- Leverage existing Veteran education programs, using multiple media and mediums to reach Veterans. Several changes affecting Non-VA Care processes have occurred since implementation of the Choice Act, such as the consolidation of staff under CBO and the implementation of the Choice Program and its related business processes.
- Adopt a single set of practices and guidance for authorizing and paying Non-VA claims (including PC3 and Choice Program requirements). Review and evaluate the existing authorization and claims processing procedures at high performing facilities and interview industry experts to determine best practices. Develop sustainable keystroke-level training to reinforce practices and guidance.
- Conduct ongoing compliance reviews to ensure effective implementation of the processes and procedures.
- Apply consistent naming standards across departments responsible for authorization and payment.
- Explore alternative business models to address administrative portions of Non-VA Care claims processing.

7.3.5 Process for Authorizing Non-VA Care

Finding

1. Authorization requirements for Non-VA Care are unclear and inconsistent among VAMCs.

- The authorization directs the Non-VA provider to render the treatment the Veteran requires and approved by VHA.¹⁷¹ Authorizations should be clear and concise to ensure there is no misunderstanding between VHA and the Non-VA provider. Considerable claims do not reflect care authorized, leading to risk of improper payment. Unclear

¹⁷⁰ Peter Kongstvedt in Essentials of Managed Care cites, “The advantage of a centralized call center is that the customer service representatives are trained to respond to all sorts of issues, not just claims-related problems, and a disadvantage is that additional extensive training on how claims are adjudicated may be needed to fully prepare customer service representatives to respond to claims inquiries. Furthermore, care must be taken to segregate claims adjudication production task from call center task to ensure appropriate focus.”

¹⁷¹VHA requires 100 percent authorization, whereas industry best practice does not. Other organizations of similar size authorize a very small percentage of care.

authorizations lead to confusion among Non-VA providers and potential risk of improper payment for unauthorized services. CPT codes are the most widely used medical nomenclature used to document medical procedures and services.¹⁷² Currently, authorizations include a brief, qualitative description of the authorized services, whereas industry best practice is to include the applicable Current Procedural Terminology (CPT) code or range of CPT codes. The CPT codes will allow the Non-VA provider some flexibility in treating the patient, but will eliminate any questions with regard to the care authorized.

- The use of vague language in authorizations can lead to misinterpretation by the provider delivering the care and VHA staff paying the claim. When Non-VA providers deliver and bill for services outside of the care authorized by VHA, improper payments result in use of resources that otherwise would be available to provide Authorized Care to Veterans. Over-payment recovery increases VHA's administrative overhead.

Recommendations

To address these findings, CBO should:

- Incorporate applicable CPT codes or ranges of CPT codes on the authorization to provide more clear and concise direction to the Non-VA provider. Adopting this industry best practice will enable VHA to reduce potential misinterpretation and risk of paying for services not authorized.
- Analyze and routinely report the reasons for referrals for Non-VA Care nationally. There is a standardized list of categories for authorizations for Non-VA Care. Analyses of these referral reasons will help VHA assess the need for Non-VA Care by clinical category, VAMC, and VISN. These analytics will also help inform VHA about clinical shortages, the demand for Non-VA Care, the need to expand the PC3 networks, and anticipate increases in Non-VA Care claims volume, staffing requirements and resource allocation.

7.3.6 Patient Centered Community Care (PC3)

Since PC3 is an evolving program, we assessed relevant business processes. We supplemented results of our site visits and data analysis with insight from both PC3 vendors, TriWest and HealthNet. The following are related findings and recommendations.

Finding

- 2. Patient Centered Community Care (PC3) is experiencing challenges in scheduling appointments and meeting administrative requirements of the PC3 vendor contracts.**
 - VHA created PC3 to expand care to Veterans, especially in rural areas, and facilitate collection of medical documentation. We found the PC3 vendors experience challenges

¹⁷² Per American Medical Association. (2015). About CPT. Retrieved from <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt.page?>

similar to those of traditional Non-VA Care—difficulty in arranging Non-VA Care for Veterans and retrieving medical documentation related to care provided outside of VHA facilities.

- HealthNet and TriWest have yet to establish adequate networks in to handle the volume or type of authorizations from VHA, resulting in an increased administrative burden and delayed access to care.¹⁷³ For example, of the 156 referrals one rural VAMC sent to the PC3 vendor, approximately half returned without action as the vendor’s network of providers was unable to accommodate to the appointment. The 2015 OIG report on PC3 supports this point:

“Neither PC3 contractor had established adequate provider networks. The PC3 contracts required full implementation of the networks in all six provider regions by April 2014. However, the PC3 Contracting Officer issued corrective action letters faulting the respective contractors for inadequate provider networks in February, May, and September 2014.” The report continues, “At one VHA medical facility, staff stated they only authorized non-urgent care such as ophthalmology under PC3 because they could not rely on the PC3 contractor to schedule appointments for other medical services due to a shortage in network providers.”¹⁷⁴

Three of four VAMCs visited indicated many providers are reluctant to join the PC3 network because of low reimbursement rates.¹⁷⁵ Assessment C indicates the PC3 vendors reimbursement rates are below Medicare.¹⁷⁶

- When HealthNet or TriWest are unable to schedule an appointment, they return the authorization to VHA. VHA is ultimately responsible for providing the care or using alternative Non-VA Care means. This adds to VHA’s administrative burden and delays the Veteran’s access to care while the PC3 vendor determines whether it has an available provider.
- HealthNet representatives indicated challenges building a network because it has to compete with already established local contracts with VHA facilities. These contracts often pay a higher percentage of Medicare reimbursement and have fewer administrative requirements than PC3.^{177,178} To mitigate this issue, CBO directed local VAMCs not to enter into any new agreements with local Non-VA providers. This will reduce competition among VHA’s Non-VA Care programs once the local contracts expire.

¹⁷³ Note: The evaluation of the adequacy of the PC3 agreements was beyond the scope of this assessment.

¹⁷⁴ VA OIG Review of VA’s Patient-Centered Community Care (PC3) Contracts’ Estimated Cost Savings Report – April 28, 2015

¹⁷⁵ Per interviews with three VAMCs

¹⁷⁶ Assessment C, Table 1-1

¹⁷⁷ Qualitative Interviews with HealthNet and TriWest Leadership

¹⁷⁸ Note: VHA pays Medicare rates for services unless they have a pre-established contract with a provider.

- HealthNet and TriWest do not return medical documentation to VHA in a timely manner, leading to payments that are inconsistent with the terms of the PC3 contract. The PC3 contract stipulates, “For [medical services] claims to be considered for payment they must include required medical documentation.”¹⁷⁹ The contract goes on to stipulate, “All submitted claims must have sufficient medical documentation to support the payment of the claim.”¹⁸⁰ According to the Return of Medical Documentation audit, the vendors provided only 79 percent of the documentation in accordance with the contract.¹⁸¹ They submitted 19 percent late and did not submit 2 percent of the required documentation. Failure of the PC3 vendor to provide medical documentation prevents VHA physicians from having up-to-date clinical information. In addition to the contract compliance issues lack of medical documentation can affect coordination of care and future clinical services.¹⁸²
- One PC3 vendor reported challenges administering the PC3 program due to inconsistencies in business process across VAMCs. For example, the vendor reported authorizations differ from one location to another and, as a result, the same documentation issued by two different VAMCs can reflect two different intents. Thus, the vendor faces challenges interpreting the authorizations and applying standardized business processes nationwide.
- Assessment C provides a detailed overview of the challenges associated with administering the Non-VA care programs.

¹⁷⁹ Per VHA Contract with HealthNet - B.3 PWS Section 2. Healthcare Resource Network i. Return of Medical Documentation

¹⁸⁰ Per VA’s contract with HealthNet, page 21 and PC3 Contract page 45 which states, “Medical documentation recording an authorized episode of outpatient care (see section 2.h.iii Quality Assurance and Surveillance Plan) shall be submitted to VA within 14 calendar days after completion of the initial appointment. If additional appointments are conducted, medical documentation shall be submitted to VA within 14 calendar days upon completion of the episode of care. Medical documentation recording an authorized episode of inpatient care shall be submitted to VA within 30 days after discharge. Critical findings have sooner report requirements as described in section 2.g.iii.1 of this PWS. The authorization may request medical documentation be returned sooner than 14 calendar days based on clinical need. Communication of information by telephone may be required when results or clinical findings necessitate an urgent response. This shall be followed up by submission of complete medical documentation within 14 calendar days. Contractors shall not bill VA until they have submitted medical documentation for both inpatient and outpatient care to VA. VA will consider exceptions for highly unusual circumstances. This process will be audited on a regular basis. Contractors may request access to VA’s Computerized Record System (CPRS)”. See Section B.4 for IT contract security requirements.

¹⁸¹ CBO Departments of Audits and Internal Controls (DAIC) Patient Centered Community Care Review of PC3 for Return of Medical Documentation, September 4, 2014

¹⁸² Per VA contract with HealthNet, VA did not provide a copy of Attachment A, which details Implementation Plan and Performance Based Payment Milestone Schedule, so we are unable to assess the degree to which these claims processing performance issues might affect incentive payments paid or performance penalties were assessed by VA to PC3 vendors.

Recommendations

To address these findings, CBO should:

- Review the terms of VHA's contracts with HealthNet and TriWest to verify documentation of network adequacy and medical documentation requirements, and VHA has the ability to hold them accountable. If so, VHA should enforce the terms governing network adequacy, billing and the provision of documentation. For example, VHA should hold PC3 payment until it has received the medical documentation corresponding to the claim at hand. If VHA's PC3 vendor contracts do not contain network adequacy and medical documentation performance standards and penalties, they should be amended to include them.
- Work with VAMCs to ensure standardization and centralization of provider contracting. Assessment C notes the need to assign responsibilities to organizations at the appropriate level of VHA's administrative hierarchy, and argues for central management of contracts (such as those under Choice and PC3).¹⁸³
- Allow PC3 vendors to enter electronic medical documentation received from Non-VA Care providers directly into the VHA system. Doing so would eliminate the additional processes of printing, scanning, and uploading these documents by the Non-VA Care staff.
- Assess alternatives for increasing utilization of Medicare's network of providers, expanding the network of physicians and potentially reducing the expense of developing a separate network for different sets of government beneficiaries.

7.3.7 Preventing Inaccurate Payments

Driven by its manual claims adjudication process, VHA is at risk for making improper payments. To mitigate those risks, VHA has implemented a number of oversight and quality assurance practices such as internal reviews and sophisticated claims scrubbers. To understand the breadth of processes in place to reduce improper payments we requested all post payment audits and reviews conducted by VHA oversight groups for the last three fiscal years.

Findings

- 1. Proactive and retrospective processes are in place to find inaccurate payments, but these practices are highly manual and there is little evidence to show how effective some mechanisms are.**
- VHA generates routine reports on claims accuracy. Internal audit teams routinely review processes and procedures to further reduce and prevent fraud, waste and abuse, and improve payment accuracy. The audit teams follow up with the VAMCs understand the root cause of errors and assist in the implementation of corrective actions. These reviews and audits monitor improper payments they are retrospective in nature; therefore, VHA

¹⁸³ Assessment C.

must invest time and money to recoup overpayments to Non-VA providers identified through these reviews and audits.

- There are a number of edit checks and quality reviews prior to payment, such as those performed with the Quality Inspector Tool (QIT) and Program Integrity Tool (PIT). These tools represent positive steps toward improving program integrity and accuracy, but they are labor intensive and can distract from claims processing, leading to an increase in the backlog. According to one VAMC, the QIT tool requires manual retrieval of two separate reports from FBCS that can take as long as four hours per day. One VAMC indicated that it has dedicated a full FTE with the sole responsibility of running the QIT tool. Another VAMC questioned whether the QIT tool identified the full spectrum of errors. This particular VAMC implemented a more robust pre-payment review process and as a result had an improper payment rate of less than one percent for FY2014.¹⁸⁴ This performance is a best practice among VAMCs; however, the processes are reliant on Non-VA Care subject matter experts and may not be repeatable among all sites.
- While there are a number of pre- and post-payment review and oversight practices in place, they are the result of the manual process for adjudicating claims. With a more automated approach, edits are performed automatically in the system; thereby, reducing manual intervention and risk of improper payment.

Recommendations

To address these findings, CBO should:

- Improve current pre- and post-payment review and oversight practices so VHA is using the most effective technological tools and practices with emphasis on automated pre-payment edit techniques.

7.4 Penalties – VHA is at Risk for Penalty Payments to Vendors Due to Timeliness Issues.

Federal and state laws mandate health insurers pay provider claims promptly. The Prompt Payment Act requires federal agencies to pay vendors in a timely manner and stipulates interest penalties be applied to late payments. When VHA enters into a contractual agreement with a Non-VA provider, it is subject to the Prompt Payment Act. If VHA does not reimburse the contracted provider within 30 days of submitting a clean claim, VHA must pay the state mandated interest rate for each day the payment is delinquent.¹⁸⁵

The contract between the insurer, in this case, VHA, and the provider submitting the claim may contain provisions regarding claims payment timeliness and penalties for late payments. Driven

¹⁸⁴ Per Request-Accuracy.xlsx. This workbook includes FY2014 IPERIA data for each sample reviewed.

¹⁸⁵ Note: Interest payments are calculated automatically in FMS based on Prompt Payment Act requirements. Interest rates may vary every six months.

by these prompt payment requirements, interest penalty payments are another indicator of an insurer’s timeliness of claims payment.

Minimizing interest penalty payments is important in effectively managing the finances of VHA. These penalties are expenditures that otherwise could be used for patient care. Commercial payers typically monitor interest payments very closely to ensure minimal costs and effective financial management. VHA does not track or monitor interest payments at the VAMC level. CBO staff at the VAMCs should be aware of the claims that are subject to interest.

VHA measures interest penalty payments in terms of dollars and as a percent of claim payments. VHA’s current standard with regard to interest is \$300 per \$1 million, or .03 percent, in paid claims. We compared Non-VA Care interest payments to commercial health care industry standards and to other government payers. Table 7-8 also shows interest payments as a percent of total claim payment during the past three fiscal years. Interest payments have decreased in the last three years from \$425,704 in FY12 to \$292,217 in FY14. In 2014, VA incurred \$292,217 in interest penalties on \$5,580,590,777 of paid claims.

Table 7-8. Interest Penalties on Late Payments

FY	VHA Performance: Interest Percentage¹⁸⁶	VHA Performance Standard	Commercial or Other Payer Benchmark¹⁸⁷
2012	.009%	.03%	0.8%
2013	.004%	.03%	0.8%
2014	.005%	.03%	0.8%
Note: VA’s Office of General Counsel is reviewing whether VAMC business practices where rates for individual authorizations are not negotiated are considered a contract subject to interest penalties. If VHA is found liable, it would be subject to pay retrospective interest penalties to Non-VA providers operating under individual authorizations and subject to greater interest penalties in the future.			

7.4.1 Process for Oversight of Interest Penalties

The Prompt Payment Act requires federal agencies to pay vendors in a timely manner. The Act stipulates that interest penalties apply when agencies pay vendors after the due date. When VHA enters into a contractual agreement with a Non-VA provider it is subject to the Prompt Payment Act. If a claim is not paid within 30 days of receipt, VHA must pay the applicable interest rate for each day the payment is delinquent.¹⁸⁸ To evaluate penalties our team interviewed stakeholders at CBO and at VAMCs. We analyzed penalty data supplied by CBO. We also discussed penalty processing with the Financial Services Center (FSC) in Austin.

¹⁸⁶ Per CBO Interest.xlsx 2014, "Penalties as % of Paid" = "Penalties" / "Paid Amount"

¹⁸⁷ AHIP Center for Policy and Research, Update: A Survey of Health Care Claims Receipt and Processing Times, 2013

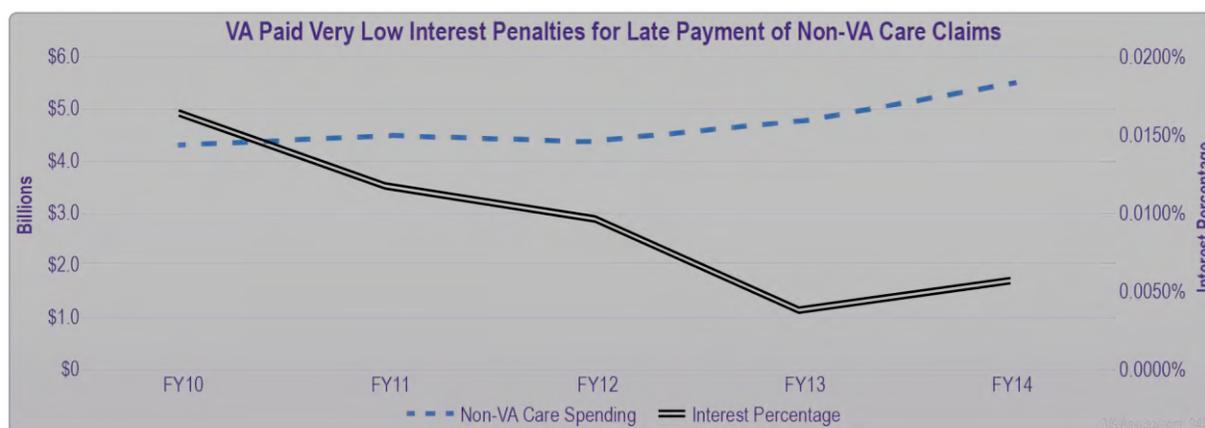
¹⁸⁸ Note: Interest payments are calculated automatically in FMS based on Prompt Payment Act requirements. Interest rates may vary every six months.

Finding

1. VHA does not conduct sufficient management and oversight activities to understand, manage, and prevent interest penalties paid to Non-VA providers.

- In 2014, VHA incurred \$292,217 in interest penalties on \$5,580,590,777 of paid claims. Of these interest penalties, 39.9 percent were paid on contract nursing home and dental claims, which are not processed in FBCS. ¹⁸⁹ VHA processes nursing home and dental claims manually in the VistA system.

Figure 7-8. Total Paid Claims and Percentage of Penalties¹⁹⁰



Source: Paid and Timeliness FY12-FY14 Data

- According to one benchmark for commercial payers, 0.8 percent of claims paid include a penalty or interest for late payment.¹⁹¹ While the 0.005 percent interest paid as a percent of claims paid for Non-VA Care compares favorably to the private sector, a significant portion (approximately 50 percent) of Non-VA Care is provided through individual authorizations and not local contracts or national contracts such as PC3.¹⁹² These individual authorizations with Non-VA providers serve as a guarantee VHA will pay for the services identified. However, because reimbursement rates are not negotiated VHA has not considered the authorizations to be a contract subject to the Prompt Payment Act. As a result, VHA did not pay interest on individual authorizations.
- In response to complaints from Non-VA providers regarding timely payment and requests for interest, VA’s Office of General Counsel reviewed the process of individual authorizations to determine what constitutes a contract between the two parties. Now,

¹⁸⁹ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by VA informatics team; \$112,359 interest in “Payment Category” “Community Nursing Home”; \$4,191 in “Payment Category” “Dental”. Total is \$116,550, which is 39.9% of the total interest paid (\$292,207).

¹⁹⁰ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by VA informatics team and Interest Report. The percentage of interest paid is calculated as "Penalties as % of Paid" = "Penalties" / "Paid Amount"

¹⁹¹ AHIP Updated Survey of Health Insurance Claims Receipt and Processing Times, 2011

¹⁹² Per CBO Purchased Care Operations Directorate

CBO considers individual authorizations, for which the rates are negotiated, the provider is identified, and services are identified as a contract. CBO recently released guidance to VAMCs instructing them that interest policies apply to these individual authorizations. OIG is reviewing whether interest should be back-paid for late payments on individual authorizations from prior years. CBO is currently awaiting the final decision of this review. If VHA is found liable, it would be subject to pay retrospective interest penalties to Non-VA providers operating under individual authorizations and subject to greater interest penalties in the future.¹⁹³ Future contracting trends such as expansion of PC3 may also affect VHA's exposure.

- While interest penalties are lower than commercial benchmarks VHA is at risk due to lack of oversight of interest at the facility level. VHA tracks the interest penalties imposed on each facility at the national level, but it is not communicated to the VAMCs. Several VAMCs indicated the inability to break down interest penalties by program. As a result, VAMCs may not be aware of how many penalties they have incurred to date.¹⁹⁴ The finance department at each VAMC monitors an interest report that includes payments for all products and services; however, finance department staff indicated challenges deciphering Non-VA Care specific interest. VHA organizes the report by obligation number; therefore, the finance staff must identify Non-VA Care obligations and extract them individually.

Recommendation

- Establish transparent reporting of interest at the facility level and stronger coordination between national and VAMC level management over interest penalties. Improving transparency at all levels will provide the ability to analyze and identify root causes of interest penalties on an ongoing basis, and proactively develop corrective actions.
- Modify reporting capabilities to report interest penalties at the program level. This will provide transparency into interest at the detailed level, and accelerate corrective actions in identifying and addressing root causes of interest charges.
- Define roles and responsibilities of staff who can drive avoidance of interest penalties. This addresses the need for awareness at the VAMC levels of the issues and risks that drive interest penalties.
- Develop an ongoing root-cause analysis and feedback program across VHA addressing interest penalties. Interest penalties are the result of process breakdowns in the claims payment process. Therefore, it is critical that the VAMC community has continuous visibility into what is working to eliminate interest penalties, and how to apply successful approaches to local requirements.

¹⁹³ Per CBO Purchased Care Operations Directorate

¹⁹⁴ Per Interviews with CBO Operations Directorate and four VAMCs

7.5 People

Our review of the people component of Non-VA Care identified themes centered on staffing and training. We detail our findings related to these functions in the following sections.

7.5.1 Staffing

To improve claims processing timeliness and accuracy in the face of increasing claims volumes, VHA needs to emphasize productivity of Non-VA Care claims processing staff. Effective staffing practices include assessing available resources, workload, and staff to develop and implement a structure that meets the organization's goals.¹⁹⁵ In addition to interviews across all levels of CBO and the VAMC, we observed staff interaction with FBCS to understand effects to productivity. Based upon our site visits and reviews, the following sections provide detail on our findings and recommendations related to people.

Findings

1. The process to pay Non-VA providers requires higher staffing levels relative to other payers.

- FBCS is heavily reliant on manual processes when compared to private sector health plans, which negatively affects timeliness and accuracy. FBCS auto-adjudicates zero percent of claims compared to private sector insurance benchmarks of 79 percent.¹⁹⁶
- The inconsistencies in job responsibilities and functions contribute to the variations in claims timeliness and accuracy results across the country. Across VA, there are inconsistent practices regarding the responsibilities of Non-VA Care staff. In some locations, claims clerks and supervisors are involved in care coordination and work closely with the clinical staff responsible for authorizations, in addition to their claims processing responsibilities. A report released in early 2015 cited the system's failure to define roles, responsibilities, and processes as a contributing factor in organizational failure.¹⁹⁷ *Essentials of Managed Care* states, "Interruptions with telephone calls severely impedes claims adjudication productivity and quality if both tasks are assigned to the same at the same person."¹⁹⁸
- The multitude of duties required of Non-VA Care staff contributes to higher staffing levels, an increase in processing errors, and slower manual processing of claims. Private sector plans more clearly segregate duties and have separate staff to perform ancillary tasks.

¹⁹⁵ Minnesota Department of Management and Budget, Strategic Staffing Guidebook, "The effective development and implementation of Strategic Staffing and its subsequent strategies and actions require the involvement and commitment of individuals who both participate in and access resources from the human resource function."

¹⁹⁶AHIP (2013) Center for Policy and Research, Update: A Survey of Health Care Claims Receipt and Processing Times

¹⁹⁷ VHA (2015) Task Force on Improving Effectiveness of VHA Governance, Report to VHA under Secretary for Health

¹⁹⁸ Peter Kongstvedt "Essentials of Managed Care" Fifth Edition, 2007 Pg. 397

Assessment I (Business Processes)

Currently, VHA staffs approximately 1.35 FTE per 1,000 Veterans using Non-VA Care services, not including current vacancies.^{199,200} Industry experts estimate commercial payers staff at about .6 FTE per 1,000 members.^{201,202} We recognize direct comparisons of Non-VA Care staffing levels against private sector health insurance plans is challenging due to the additional tasks Non-VA Care staff perform. For example, most private sector health plans employ provider relations staff to outreach to the health care provider community to facilitate issues affecting timely and accurate claims processing; and VHA does not. Other payers also employ member services staff dedicated to responding to member inquiries related to claims and eligibility; again, VHA does not. VHA claims clerks answer both provider and Veteran inquiries in addition to their claims processing responsibilities. Lack of automated technology also requires additional staff to process and pay claims.

- High staff vacancy rates and poor retention contribute to delays and errors in claims payment, which is further exacerbated since VHA does not have adequate technology.²⁰³ Staff vacancies lead to higher overtime costs, inexperienced staff, and a constant focus on employee recruitment, training, retention, and negatively affects the timeliness and accuracy of claims payments. During the implementation of the Veterans Choice Act in October 2014, CBO leadership reported there were 295 vacant positions (out of 1,982 authorized positions) for Non-VA Care claims clerks, supervisor, and support positions, such as clinical staff and budget technicians.²⁰⁴ Since the implementation of the Veterans Choice Act, CBO has indicated some progress reducing the number of staff vacancies; however, during our site visit interviews, we found staffing retention and vacancy rates to be a significant and widespread challenge facing local Non-VA Care operations.²⁰⁵ In addition, CBO staff noted that Non-VA Care spends \$1.7 million per year on claims processing staff overtime.²⁰⁶

¹⁹⁹ Calculation: Number of claims processing staff (1,687) divided by the number of unique Veterans that received Non-VA Care (1,252,710) x 1,000. The source of the claims processing staff is the CBO Purchased Care Operations Directorate and the source for the Veterans that received Non-VA Care is per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines.

²⁰⁰ MITRE attempted to acquire Sherlock Benchmarks particularly for staffing, but was not able to come to an agreement with Sherlock.

²⁰¹ The volume of NVC claims represents a subset of all services rendered to the Veteran who access Non-VA Care. In contrast, commercial payers process claims for all services their members use. This difference in the calculation of this measure further demonstrates the disproportionate staffing levels at VA.

²⁰² Per Navigant Consulting industry subject matter expertise

²⁰³ CBO Purchased Care Operations Directorate indicated that they began tracking staff turnover rates; however, they only began tracking this data in October 2014, limiting our ability to draw comprehensive conclusions. In addition, CBO tracks and reports turnover data on a pay period basis.

²⁰⁴ Per CBOPC OPS FTEE by VISN.xlsx prepared by CBO Purchased Care Operations Directorate

²⁰⁵ As of August 2015, there are currently 83 vacancies within Non-VA Care; however, over that same time, CBO transferred a number of positions to other departments, reducing the total number of authorized positions in Non-VA Care to 1,871. The CBO provided the updated number of staff vacancies and authorized positions but the data was not independently validated.

²⁰⁶ Per Interviews with CBO Purchased Care

- CBO Purchased Care’s headquarters has significant staffing vacancies. The requisite staff members are responsible for the oversight and administration of the overall Non-VA Care program. When leadership and key positions are vacant the implementation of necessary process improvement falters, and negatively affects claims processing performance.
- Due to limited availability of VA Care services and clinical staffing, VHA staff reported increases in Non-VA Care claims volume for some services, particularly behavioral health. At one VAMC staff noted that authorizations for behavioral health services have more than quadrupled, and described challenges with getting Non-VA behavioral health specialists to see VHA patients. The authorization process and the claims processing for behavioral health are often more complex and time consuming than more clearly defined medical or surgical services. Because of these complexities, many commercial payers outsource the management of behavioral health to firms that specialize in that field. The increase in Non-VA Care claims volumes requires adequate staffing and/or outsourcing to process claims timely and accurately.

Recommendations

To address these findings, CBO should:

- Refine job responsibilities so claims staff can specialize in core claims processing functions.²⁰⁷ These roles and responsibilities should be standard across all VAMCs.
- CBO is assessing staffing levels across Non-VA Care. An objective of this process is the development of enterprise wide productivity standards. The study is scheduled to be completed in June 2015, and the results were not available at the time of this report.²⁰⁸ We support CBO’s efforts and recommend as Non-VA Care continues to evolve continually assessing staffing levels are appropriate to ensuring the accuracy and timeliness of claims processing.
- Continue to build the tiger team and deploy resources to alleviate claims backlogs, assist VAMCs or VISNs with vacancies and focus on timeliness and accuracy problems.²⁰⁹ To manage spikes in claims volume and to work Choice claims, CBO trained clerks who can provide assistance to Non-VA Care departments across VHA. When deployed to assist VAMCs these teams are called VHA Tiger teams.

²⁰⁷ Peter Kongstvedt’s book *Essentials of Managed Care* discusses the advantages and disadvantages of dividing the roles and responsibilities of claims processors and member and provider focused delivery services. One advantage of claims clerks taking calls is the ability to resolve errors on claims and suspended claims and a potential disadvantage is that the caller may be inquiring about other issues that require transfer to a member or provider service representative. Kongstvedt also argues that constant interruptions of calls with members and providers would deter the accuracy and timeliness of the auto-adjudication process.

²⁰⁸ Per Interviews with CBO Purchased Care

²⁰⁹ Tiger teams can remotely access the FBCS system at local VAMCs to process claims.

- Review 2015 timeliness and accuracy data from all 21 VISNs, identify underperforming VAMCs, and utilize tiger teams to improve the timeliness and accuracy of processing Non-VA Care claims.

7.5.2 Training

Training is integral to improving timeliness and accuracy when paying claims. Effective training increases job satisfaction and improves work performance, particularly if training is tied directly to the mission.²¹⁰

Leading practices are to provide mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”²¹¹ Newly hired Non-VA Care staff members are assigned mentors who provide hands-on training, particularly on IT systems used to complete tasks. Due to the complexities of Non-VA Care claims processing, training is particularly essential to prevent deficiencies in Non-VA Care claims payment timelines and accuracy.

Finding

1. Training for Non-VA Care claims payment staff is inconsistent not comprehensively applied across VHA.

- Lack of consistent, comprehensive training requirements across Non-VA Care affects VHA’s capability to ensure that CBO training reaches the intended audience and improves claims timeliness and accuracy. CBO leadership indicated adequate training is available for claims clerks and training materials are regularly updated; however, this training is not mandated for staff (aside from training on one FBCS Patch, which is a system upgrade/improvement to the FBCS).²¹² At all four of the VAMCs we visited, Non-VA Care staff indicated that training was inconsistent. Claim clerks and supervisors indicated differences in how claims are processed at each VAMC. Assessment C noted that, “Existing VA guidance pertaining to purchased care is scattered, sometimes outdated, and inconsistent in setting clear standards, leaving local facilities to develop their own policies and procedures.”²¹³

²¹⁰ Per University of Rhode Island (2003). [Labor Research Center] Job Satisfaction. Retrieved from <http://www.uri.edu/research/lrc/scholl/webnotes/Satisfaction.htm>. “An employee’s attitudinal response to his or her organization. As an attitude, job satisfaction is summarized in the evaluative component and composed of cognitive, affective, behavioral components. As with all attitudes, the relationship between satisfaction and behavior, most specifically job performance”

²¹¹ Society for Human Resources Management (SHRM), Onboarding New Employees: Maximizing Success

²¹² Per Interviews with CBO Purchased Care and VAMCs

²¹³ Assessment C - Page vi

- At present, VHA does not offer training programs for monitoring and managing Non-VA Care targeted to supervisors. A report released by the Office of Inspector General in 2009 presented similar findings, “VHA has not developed current and comprehensive fee policies and procedures, identified core competencies and established mandatory training requirements for fee staff, and implemented clear oversight responsibilities and procedures for the Fee Program. Furthermore, while the National Fee Program Office offers training for fee staff and supervisors, VHA does not require these employees to take the training.”²¹⁴
- One fee supervisor told our team it can take up to a year to train someone to properly process claims. With proper desk-level procedures, VHA can shorten the training window.²¹⁵
- As noted above, the lack of a centralized claims processing system and the lack of standardized business processes hamper VHA’s ability to develop standardized or keystroke training for all claims clerks. Since keystroke-level training and desk-level procedures are not available CBO and local VAMCs are forced to engage in one-on-one training efforts that are lengthy and not in uniform across VHA. Extended training periods result in timeliness and accuracy issues during these transition periods.²¹⁶
- Additionally, VHA lacks an FBCS testing sandbox (training environment) for onboarding claims clerks; a clerk’s first exposure to keying claims is with live claims in the production system.²¹⁷ A testing sandbox is a training tool for new hires to learn and understand the system without affecting live claims.

Recommendations

To address these findings, CBO should standardize the Non-VA Care claims processing methods and train claim clerks on the new methods by following the six recommendations below.

- Emphasize FBCS training and capabilities. In addition, when there are changes to policy, system, or procedures, CBO should include these changes in a recurring training program for all affected staff. The implementation of a structured training program will enable consistency across all Non-VA Care claims processing. Best practices include emphasizing the importance of onboarding training, particularly ensuring that new hires understand the organization’s role of business, products, and the meaning of the systems processing instructions.²¹⁸
- Identify and share positive deviant VAMCs Non-VA Care claims processing through analyses of the IPERIA reports and other audits. CBO should coordinate with VAMCs to

²¹⁴ OIG Audit of Veteran’s Health Administration’s Non-VA Care Outpatient Fee Program, Report No. 08-02901-185, August 3, 2009

²¹⁵ Per Interview with Salt Lake City VAMC

²¹⁶ Per Interview with CBO Learning and Development Directorate and four VAMCs

²¹⁷ Per Interview with CBO Learning and Development Directorate

²¹⁸ Peter Kongstvedt “Essentials of Managed Care” Fifth Edition, 2007 Pg. 397

facilitate targeted training programs that communicate leading internal practices to underperforming VAMCs, and provide the necessary training to improve payment timeliness and accuracy.

- Develop and conduct training in customer service skills for claims processors whose roles also include call center duty. Claims clerks and call center representatives require different training.
- Create a training program focused on the supervisory skill set needed by Non-VA Care supervisors. VHA should initiate and implement training focused on staff retention and professional development.
- Create a FBCS environment for staff to train on before keying live claims.
- Formulate a training plan that includes training methods that are interactive, engaging, and conducted consistently. In accordance with industry best practice, VHA should develop a comprehensive training program that includes classroom, web-based and CD-ROM courseware, conference calls, webinars, online simulations training in conjunction with their mentors. In addition, assessing the effectiveness of training is also as important to measure the effect of training staff competency and improvement.

7.6 Non-VA Care Summary of Findings and Recommendations

The following table summarizes the findings and recommendations presented in this chapter, providing further detail to identify each finding’s significance and each associated recommendation’s timeline and effect.

Table 7-9. Summary of Findings and Recommendations

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
Patient Centered Community Care (PC3) is experiencing challenges in scheduling appointments and meeting administrative requirements of the PC3 vendor contracts.	CBO should work with VAMCs to ensure standardization and centralization of provider contracting has been realized. Consider allowing PC3 vendors to directly enter electronic medical documentation received from Non-VA Care providers into the VHA system	Tier 1	Short	Process, Technology

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
VHA does not conduct sufficient management and oversight activities to understand, manage, and prevent interest penalties paid to Non-VA providers.	Analyze and identify the root cause of interest penalties and provide these analyses to VAMCs on a regular basis to ensure VHA tracks interest penalties appropriately, and, when penalties exist, implements corrective action.	Tier 1	Short	People, Process, Technology
Proactive and retrospective processes are in place to find inaccurate payments, but these practices are highly manual, in nature, and there is little evidence to show how effective some mechanisms are.	Improve current pre- and post-payment review and oversight practices, so that VHA is using the most effective and highly automated tools and practices with emphasis on automated pre-payment edit techniques.	Tier 1	Short	Process, Technology
Training for Non-VA Care claims payment staff is inconsistent and not comprehensively applied across VHA.	Emphasize FBCS training and capabilities. Emphasize the importance of onboarding training. Develop and conduct training in customer service skills for claims processors.	Tier 1	Short	Process, People

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
Inadequate Non-VA Care claims submission guidance contributes to increased workload and payment errors.	Adopt a single set of practices and guidance for authorizing and paying Non-VA claims (including PC3 and Choice Program requirements). Apply consistent naming standards across departments responsible for authorization and payment.	Tier 2	Short	People, Process
Policy complexity for Staff and Non-VA Providers Results in a High Risk of Improper Payments and Causes Confusion, Inefficiencies, and Errors in a Manual Environment	Adopt a single set of practices and guidance for authorizing and paying Non-VA claims (including PC3 and Choice Program requirements). Apply consistent naming standards across departments responsible for authorization and payment.	Tier 2	Short	People, Process
Authorization requirements for Non-VA Care are unclear and inconsistent among VAMCs. Considerable claims do not reflect care authorized, leading to risk of improper payment.	Incorporate applicable CPT codes or ranges of CPT codes on the authorization to provide more clear and concise direction to the Non-VA provider. Analyze and report routinely the reasons for referrals for Non-VA Care nationally	Tier 2	Short	People, Process, Technology

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
The process to pay Non-VA providers requires higher staffing levels relative to other payers.	Redefine job responsibilities to be more narrowly defined so claims staff can specialize in core claims processing functions. These roles and responsibilities should be standard across all VAMCs. Establish CBO-wide productivity standards for staff Continue to build the tiger team to quickly deploy resources and alleviate claims backlogs, assist VAMCs or VISNs with many vacancies and focus on VAMCs with timeliness and accuracy problems	Tier 2	Short	Process, Technology
Training for all staff responsible for processing and paying Non-VA Care claims is not consistently and comprehensively applied across VHA. Additionally, the lack of standardized policies and procedures at VHA contributes to inconsistencies with training.	Standardize the Non-VA Care claims processing methods and train claim clerks on the new methods	Tier 2	Short	People, Process, Technology

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
Legend				
Significance	Tier 1 = Direct effect to payment and billing timeliness and accuracy Tier 2 = Supporting actions to improve payment and/or billing timeliness and accuracy			
Timeline	Short Term=0-2 years, Medium=3-4 years, Long Term=>4 years			
Impacts	People Process Technology			

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

8 Analysis of Information Technology—Lack of Automation and Integration Prevent VHA from Optimizing Performance in both Collections and Payments.

8.1 Introduction

Information Technology (IT) provides the foundation for the execution of VHA’s revenue billing and collections and Non-VA Care vendor reimbursement processes. While Assessment H (Health Information Technology) from the Choice Act provides an in-depth assessment of VA’s IT Strategies, and Assessment C provides an assessment of the authorities and mechanisms for purchased care, we focused on evaluating the effectiveness of VHA’s primary IT systems used for billing and collection of revenue for VA Care and for processing payments for Non-VA Care.

The overarching finding and challenge identified for the IT systems during our assessment is that a lack of integrated automation is preventing VHA from optimizing collections and payments processes and outcomes.

8.1.1 Information Technology—History

The primary IT systems used to execute business processes across VHA Care and Non-VA Care Operations are the Veterans Health Administration Systems and Technology Architecture (VistA), Computerized Patient Record System (CPRS), and the Fee Based Claims System (FBCS).

Developed in-house in the 1990’s from earlier VA information systems (the Decentralized Hospital Computer Program) VistA is an integrated outpatient and inpatient information system that supports day-to-day operations at local VHA facilities. VistA “consists of 104 separate computer applications, including 56 health provider applications; 19 management and financial applications; eight registration, enrollment, and eligibility applications; five health data applications; and three information and education applications. Besides being numerous, these applications have been customized at all 128 VHA sites.”^{219 220}

In the 1990’s, CPRS was released to provide an updated graphical user interface (GUI) to complement VistA capabilities. CPRS is a desktop client application that provides a single Windows-style interface for health care providers to review and update any patient information, to place orders, including medications, special procedures, x-rays, patient care nursing orders, diets, and laboratory tests stored and managed in the VistA Electronic Health Record (EHR).²²¹

²¹⁹ Part III, VA Consolidated Financial Statements for FY2014, page 98. Retrieved from <http://www.va.gov/budget/docs/report/2014-VAparPartIII.pdf>

²²⁰ First View Federal TS ,Veterans Health Administration Chief Business Office Current Enterprise Architecture Assessment Deliverable 0002AA v1.7.2, December 31, 2013

²²¹ The MITRE Corporation (2015). Assessment H (Health IT) Final Report. p115

Implemented throughout VHA in 2010, FBCS processes and pays Non VA medical care claims. FBCS electronic data processing allows for automated workload assignments and data capture for reporting. FBCS creates, tracks, and manages claim authorizations, and makes claim payments.²²²

8.1.2 Modernization Efforts

VistA 4, expected to be delivered in fiscal year 2018, is the next evolution of VistA. “VistA 4 is intended to harness the powerful core of software and business processes embedded within VistA and apply a modern computing architecture that is modular and extensible, fully leveraging VA’s investment in VistA, and allowing for an interoperable EHR that provides patient-centered care to Veterans, Service members, and their dependents.”²²³ One of the objectives for VistA 4 is to “Establish and maintain methods to develop business (clinical and administrative) processes and revise existing procedures and policies that advance VA health care and health informatics capabilities”²²⁴ VistA 4 capabilities will eventually replace CPRS. Assessment H provides more insight and analysis of the VistA 4 (i.e., VistA Evolution) program.

VHA initiated the Health Care Payment System (HCPS) development to be an automated system to replace FBCS. According to the Deputy Chief Business Officer (DCBO) for Purchased Care, the CBO identified a need in 2008 for a centralized claims processing system that would help improve Non-VA provided care payment accuracy and claims processing timeliness.²²⁵ The system is approximately two-thirds completed, but as the incorrect funds were used for purchase and development it requires appropriate funding before it can be completed and put into operation.

In addition to these major system developments, VHA has plans to make incremental improvements to current tools. For example, VHA is improving the electronic Insurance Verification (eIV) functionality and strategizing on enhancements to FBCS.

Previous reports from the OIG and GAO have identified weaknesses in VA’s control and oversight of payments made to Non-VA entities and have identified areas for improvement in collection reimbursements from third parties Appendix E provides an overview of previous reports addressing IT systems.

²²² Department of Veterans Affairs Office of Inspector General. (2015). Audit of Non-VA Medical Care Claims for Emergency Transportation. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-13-01530-137.pdf>

²²³ Department of VA, VistA Evolution Program Plan, March 24, 2014, page 4. Retrieved from http://www.osehra.org/sites/default/files/vista_evolution_program_plan_3-24-14.pdf

²²⁴ Department of VA, VistA Evolution Program Plan, March 24, 2014, page 6. Retrieved from http://www.osehra.org/sites/default/files/vista_evolution_program_plan_3-24-14.pdf

²²⁵ Department of Veterans Affairs Office of Inspector General. (2015). Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-14-00730-126.pdf>

8.1.3 Key IT Systems Supporting Collections and Payments—Current State

Table 8-1 provides a summary of the primary and support systems used by key components of revenue cycle and Non VA Care operations. We recognize that this list may not include all systems and tools; our intent is to provide a summary of the primary systems and tools identified during our assessment.

Table 8-1. Key VHA Revenue Cycle and Non- VA Care Payment Systems

Process Area	Key Components	Key Systems and Tools
Patient Access	<ul style="list-style-type: none"> ▪ Scheduling/Preregistration/Registration <ul style="list-style-type: none"> ○ Insurance identification ○ Veteran eligibility ○ Demographics 	VistA Insurance Capture Buffer (ICB) Electronic Insurance Verification (eIV)
Clinical Processes	<ul style="list-style-type: none"> ▪ Clinical Documentation <ul style="list-style-type: none"> ○ Timeliness and accuracy ○ Response to physician queries ▪ Coding <ul style="list-style-type: none"> ○ Receipt of clinical documentation ○ Coding outpatient and inpatient Encounters ○ Health Information Management Services (HIMS) 	CPRS Nuance (Computer Assisted Coding) VistA Billing Package Third Party Billing Software Billing Workflow Driver
Patient Accounting	<ul style="list-style-type: none"> ▪ Billing <ul style="list-style-type: none"> ○ First- and third-party billing ○ Bill editor/edit checks ○ Submission to payer ○ Specialty billing ▪ Accounts Management <ul style="list-style-type: none"> ○ Follow up ○ Denials management 	VistA (IB and AR) VistA Chargemaster Nuance CPAC Workflow Tool Payment Variance Tool Denials Management Tool FBCS
Vendor Reimbursement	<ul style="list-style-type: none"> ▪ Vendor claim adjudication <ul style="list-style-type: none"> ○ Authorizations ○ Vendor payment 	FBCS VistA CPRS Program Integrity Tool Quality Inspector Tool

- VistA is currently the primary IT system to execute business processes. VistA includes AR and Integrated Billings (IB) modules. The AR module maintains the detailed records for

each receivable while the IB module provides functionality to create first-party and third-party bills. VistA also allows for the capture, maintenance, and storage of insurance data through the Insurance Capture Buffer (ICB).²²⁶ Non-VA Care also uses VistA to perform the majority of the non-adjudication functions and for adjudicating claims not processed in FBCS.²²⁷ Assessment H provides a more detailed assessment of VHA's information systems, including VistA.

- The clinical documentation captured in VHA's Clinical Patient Record System (CPRS) is the primary input required to code patient encounters. For VA Care, accurate coding of encounters is a prerequisite to third-party reimbursements. Non-VA Care uses CPRS predominantly for documentation of consults, and medical records management. Assessment H and Assessment F provide a more detailed assessment of VHA's CPRS.
- VHA staffs use FBCS for a majority of Non-VA Care claim processing. They also use FBCS to manage the authorization and payment for Non-VA medical care. FBCS interfaces with CPRS to populate basic fee consult information. FBCS automates certain elements of the administrative review. It allows for electronic claims submission and reimbursement.
- Nuance (QuadraMed) is VHA's national encoder software package. It is a coding and claims scrubbing system that checks encounters against national integrated billing edits that check for common errors. The Nuance system also has an audit and reporting mechanism and is widely used and accepted in the private sector.

We used a qualitative approach to evaluate the primary IT systems and tools during our assessment. Our approach included interviews with system users, process and system walkthroughs, review of industry benchmarking and comparison of key system functionality to industry best practices.

Overall, we noted that VHA's technical architecture around the revenue cycle lacks interoperability, causing many functions, or departments, within VA to operate in silos with limited visibility into the lifecycle of a claim. For Non-VA Care operations, FBCS does not process all of the required types of Non-VA Care vendor claims. Both revenue cycle and Non-VA Care systems require staff to be trained on and logged in to several different systems to perform their job responsibilities. In addition, the lack of key automation of activities and integration and access to the various systems and data necessitates a high degree of manual intervention for revenue cycle and Non-VA Care processes.

²²⁶ First View Federal TS ,Veterans Health Administration Chief Business Office Current Enterprise Architecture Assessment Deliverable 0002AA v1.7.2, December 31, 2013

²²⁷ Claims not processed through FBCS include: dental, pharmacy, adult day care, bowel and bladder, home health for contract nursing homes claims, and dialysis. Dialysis claims processed in separate COTS product, not FBCS or VistA.

8.2 VHA Revenue IT Findings

8.2.1 Inadequate Technology Prevents Effective Veteran Education, Delays Veteran Payment Plans and Delays Veteran Co-payment Collection.

In the private sector, financial counselors and the technology play a significant role in helping patients understand payment options, set up payment plans, pay out-of-pocket expenses, and resolve balances. Effective financial counseling available during Patient Intake serves to improve overall patient understanding and satisfaction as well as first party collections. Technology also enables private sector providers to calculate estimated charges and providing patients with estimated out-of-pocket expenses prior to rendering services. Consequently, private providers typically request a deposit or pro-rated amount during pre-registration or registration. Patients are instructed to be prepared to meet financial obligations prior to or on the day of the scheduled service. Leading practices are to train patient access personnel to appropriately identify and communicate with these patients.

Findings

- 1. VHA does not have automated tools or functionality to provide real-time Veteran out-of-pocket responsibilities during scheduling, pre-registration, or registration/check-in.²²⁸**
 - The complications associated with service connected status, priority groups and tiered co-payment structures confuse VHA staff and Veterans alike. Lack of technology to assist with this determination negatively affects VHA's ability to collect.²²⁹ Additional detail is located in the First Party collections section.
- 2. VHA systems do not allow electronic submission of Veteran's payment plan forms.**
 - Currently the Veteran accesses the payment plan forms online, prints a completed form and sends via postal mail to each CPAC for manual review and processing. Our interviews with CPAC staff noted that CPACs can experience backlogs of payment plan processing due to process inefficiencies and volume of requests.²³⁰
- 3. VHA systems lack functionality to automate first-party refunds and claims matching.**
 - VHA's first party refunds and claims matching process is extremely labor intensive and inefficient.²³¹ First party claims matching is the process of matching insurance payments and Veteran co-payments to appropriate claims for the correct dates of service. VHA uses

²²⁸Qualitative interviews at three CPACs indicated that this was an issue.

²²⁹Qualitative interviews at three CPACs indicated that this was an issue.

²³⁰One CPAC noted that they are experiencing a backlog of 30-45 days, equating to roughly 500-600 payment plans.

²³¹Qualitative interviews at two CPACs indicated that this was an issue.

this information to offset co-payments, refunding the Veteran once insurance companies pay amounts due (it is offset dollar for dollar).²³²

- Our site visits and interviews found that the VHA claims-matching process is a manually intensive and often requires substantial rework when multiple insurance payments apply to a patient's claim. Interviews with CPAC staff highlighted that CPACs have a current claims matching backlog.²³³ This necessitates VHA staff overtime hours, as well as use of outside contractors, to work and minimize the backlog.
- CPAC staff members must manually review all Non-VA Care co-payments made by Veterans in Non-VA facilities, to determine and process refunds due. This process and lack of adequate technology adds tremendous workload and pressure on already inundated CPAC staff.

4. The Treasury Department's online platform, www.pay.gov, periodically posts payments to the wrong Veteran's account.

- This site is used to help facilitate the collection of co-payments due from Veterans. Our interviews found that misapplication of payments is due to the website prompting Veterans to input their account number and amount due in a free-text field on the portal. Misapplied payments to Veteran's accounts require additional CPAC resources to investigate and resolve the issue.

Recommendations

- Working with OIT, VHA should invest in tools, technology, and/or functionality that will allow staff to a) provide patients with out-of-pocket responsibilities and b) perform automatic claims matching and adjustments for co-payments (for both VA and Non-VA Care). Patient Intake staff should electronically access the VHA co-payment schedules (see 10A.2.5.2) to explain co-payment amounts specific to the Veteran's status.
 - Enhancing system functionality for the generation of enhanced itemized statements for patients including information related to third-party payers billed, detail of charges (description, quantity, and amount), payments and adjustments, and contact information for billing and other questions will improve the Veteran's visibility into amount owed to VA.
 - Invest in technology that will automate the Veteran payment plan process. This includes functionality to calculate the optimum payment plan for each Veteran based on the patient's ability to pay and the organization's payment plan guidelines. The solution would incorporate a financial screening program that would create a plan in the best interest of VA and the Veteran, yielding a higher inclination to pay, and likely decreasing first party AR days-outstanding.

²³²Based on review of 38 CFR Part 17, RIN 2900-AP24. Expanded Access to Non-VA Care Through the Veterans Choice Program. November 5, 2014.

²³³Qualitative interviews with two CPACs identified this as an issue. One CPAC site identified a claims matching backlog.

- Coordinate with the Department of Treasury to redesign the user's experience on the www.pay.gov website and add the functionality to create unique profiles for each Veteran based on a secure unique identifier. By associating each patient's bill with a Veteran's unique identifier, it will allow the Veteran to log onto the www.pay.gov website, access their individual profile, and then have the ability to view their statements and submit payment for all associated outstanding debts to VA. This would assist in reducing misapplied patient payments, as well as reduce the administrative burdens of VA staff, decreasing overtime hours and allowing staff to focus additional time on other job responsibilities.

8.2.2 Significant Limitations in the Integration of Tools and Functions Across Clinical and Revenue Management Systems Increase Collection Delays and Denials.

Findings

- 1. VistA has interoperability limitations (both internally and externally) that inhibits VHA's ability to bill and collect revenue accurately and timely.**
 - While interviews with VAMC staff revealed that the VistA system is working well for VHA clinicians and coders, they also revealed that VHA coders work in multiple systems (VistA and Nuance) to complete the same tasks. This results in coders losing valuable coder productivity due to multiple logs-ins to access different systems, inputting redundant data, and performing manual checks to ensure information matches.
- 2. VHA systems are not integrated, inhibiting consolidated management reporting.**
 - We learned on our site visits that in order for supervisors to pull staff productivity metrics they have to switch between dashboards contained in multiple systems to aggregate reports.
- 3. VHA's clinical systems do not automate diagnosis and linking functions as efficiently as private sector systems.**
 - In our experience, many private sector organizations are transitioning to technological solutions, such as computer-assisted coding (CAC) devices, to automate clinical documentation. CAC devices scan electronic documentation to identify key items, suggest medical codes that match the terms in the documentation, and convert text into ICD-9/ICD-10 and Current Procedural Terminology (CPT) codes.²³⁴
 - During site visit interviews, clinicians reported challenges using CPRS to link encounters with clinical documentation, which creates follow-up work for coders to resolve incomplete patient files. Interviews revealed that VA purchased ICD-10 coding software from Nuance but has not yet provided clinicians and coders with CAC devices.
- 4. The VHA Chargemaster does not automatically apply codes to certain procedures and supplies as is industry standard.**

²³⁴ International Classification of Diseases

- According to industry experts, the Chargemaster automatically applies codes to certain procedures and supplies so coders do not have to. The Chargemaster is typically updated with codes and charges immediately when the updates are available, and integrated with the hospital's coding system. According to VHA's HIMS, VHA's Chargemaster is not integrated with Nuance and does not apply codes automatically, requiring Coders to do so manually.

Recommendations

- VHA, working with OIT, should prioritize the integration of tools (and functions) across clinical administration and patient accounting systems. In particular, we recommend that VHA integrate medical records, coding, chargemaster and billing systems with single sign-on to facilitate expedited claims generation and payment. In addition, all non-clinical decision making should be automated, such as the determination of whether medical services fall under Veteran's service connected disability. One integrated system will allow billers and coders to access the information they need from one site rather than multiple sites, reducing human error, and time needed to complete tasks.
- Consider providing coders and clinicians with improved tools. CAC devices will help VHA streamline previously manual clinical documentation practices for clinicians and increase coder productivity by helping coder's process claims more quickly.²³⁵ Investigate system enhancements to CPRS to help support clinician coding, such as auto coding functionality.
- Conduct studies in clinical management systems that have proven successful in large integrated health care systems in the private sector. We understand that VA is considering migrating HIMS coding and claims editing functionality to an automated billing system. VA should consider investing in an automated billing system option since it has the potential to reduce VA's operational costs and increase the quality of claims submitted to third party payers.

8.2.3 Annual CPT® Code Updates are not Implemented Timely Due to Inefficiencies in the VistA Update Process.

Finding

1. Annual CPT® code updates are released every October/November by the American Medical Association. As they are effective January 1 of the next year, the industry standard is to load, test and implement CPT® updates prior to the end of the year.

- VHA's annual CPT® code update process requires significant collaboration between HIMS, CBO, and OIT. While private sector providers update their systems with the new codes by January 1, our interviews revealed that VHA's process operates under a five to six month delay across all VAMCs and CPACs. This delay has a significant effect on revenue

²³⁵ Note: We understand that VHA previously sought CAC devices; however, efforts did not materialize due to funding issues.

operations as VHA cannot bill a payer until the new CPT codes and prices are available. CPAC billing staff stated that they either hold bills where the CPT® codes have changed, or bill the provider expecting to receive an initial denial. Coding staff will also hold encounters if the CPT® codes need to be updated. This creates a coding backlog that may require the use of coding contractors to resolve.

- Once the new CPT codes are released every October/November, HIMS will post the new codes in January. The HIM Director stated that the 2015 CPT annual update was released to the field via a patch on January 8. CBO also updates the VHA Chargemaster with prices for each CPT code via a patch that is released by January 1. Once HIMS and CBO have posted the CPT codes and prices, OIT must develop and deploy a new patch.
- We learned that VHA's five to six month delay is due to the processes associated with developing, testing, and deploying the annual CPT patch to all VAMCs and CPACs. In developing the patch, OIT must review the CPT codes and Chargemaster files, build a patch using existing templates, conduct internal testing, and prepare developer documentation. OIT selects VHA test sites to release the new patch to, which requires the signing of a Memorandum of Understanding (MOU) with VAMC and VISN leadership. This testing, both internally and in the field, includes several steps for quality assurance and product approval. Once the patch is successfully tested in the field, it is released nationally. This process is extensive and involves feedback and approval from several entities within VHA

Recommendations

- Work with OIT to revise the current approach to implementing and releasing annual CPT® code updates so they are available by January 1. For example, develop multi-year MOUs to avoid having to select new test sites each year. This will bring VHA into alignment with the appropriate billing standards and the private sector practices.
- Planning efforts to integrate a patient accounting system should include an automated annual CPT code update process that requires less extensive system patches.

8.2.4 VHA Billing Staff are Manually Reviewing 100 percent of Claims Subsequent to Automated Claim Edits, Resulting in Significant Workload and Affecting Billing Timeliness.

Finding

1.VHA's percent of manual review of claims is extremely high compared to the industry standard of 10-20 percent. The maturity of private sector billing edits requires less manual review.²³⁶

²³⁶Qualitative interviews at three CPACs indicated that this was an issue. 10-20% industry standard is based on feedback from industry subject matter experts.

- We understand two primary drivers necessitate the manual review of VHA claims prior to submission to third-party payers.²³⁷
 - VHA has to test for service connectedness, a function that is unique to VA.
 - It is common for a VHA patient to have multiple services in one day, which adds to the complexity of the bill as driven by the policy.
- Due to the manual billing of claims, the CPACs have a combined 607 billers. In our experience with private sector, VHA could reduce the number of billers required if a manual review each claim after the claim editor process was not required.

Recommendations

- VHA, in coordination with VA OIT, should prioritize funding and accelerate planning efforts to integrate a patient accounting system that includes automated billing that will support algorithmic edits and, where appropriate, automate correction of claims to minimize manual review requirements. Once a new automated solution is developed and put into place, VHA should reevaluate staffing levels to account for the change in workload and reallocate personnel accordingly.

8.3 Non-VA Care IT Findings

8.3.1 Lack of Automation for Non-VA Care Claims Processing (via FBCS) Delays Payments, Causes Inaccuracies, and Increases Improper Payments.

In the private sector, payer systems typically automate claims processing. These payer systems carry an edit status or disposition. By assigning a disposition to an edit, the payer creates a framework to deny claims automatically, without manual intervention. Edits that are more complex carry a “suspend” disposition, and, in a typical commercial claims processing system, it is only those claims with a “suspend” status that require manual intervention.

Finding

1.VHA’s claim adjudication system, FBCS, lacks the functionality to adjudicate claims automatically.²³⁸

- Manual review of edits is costly and time-intensive. Currently FBCS does not maintain an edit status or disposition. Clerks must manually works each edit that posts to the claim. To work the claim edit, a clerk analyzes the edit, edit description and other claims information to determine if the edit should be marked as “pay,” “deny” or “reject.”

²³⁷Qualitative interviews at three CPACs and interviews with CBO leadership described this process.

²³⁸ As of January 2015, 0 percent of all claims auto adjudicated (Source: HAC Interview)

- The lack of automation leads to issues with paying claims timely and accurately, and when VA cannot pay for Non-VA -VA Care timely, VA accrues interest penalties.²³⁹ A white paper released in 2011 addressing VA's "fee" program also noted the significant effect of limited automation of VA's claims systems on efficiency and accuracy of processing Non-VA and VA claims.²⁴⁰ The manual nature of the system is the largest contributors for errors in the last three Improper Payments Elimination and Recovery Act (IPERA) reports.²⁴¹ In addition, Assessment C found, "Others have criticized the lack of updated automated processes for claims handling by VHA under the traditional purchased care program, noting that the primary application being used to handle claims from Non-VA providers is more than two decades old."
- Manually applying rules to claims inherently takes longer than computerized application of the same rules. For each item that VHA can automate, VHA saves processing time, reducing the payment window for claims and reducing the staff workload. Additionally, manual processes will never be as accurate as computerized processes – each manual step that can be automated leads to greater accuracy, increasing overall accuracy of claims payment.
- Although VHA is automating FBCS, there are additional areas that require manual claims reconciliation. While observing individual claims clerk, our team noted several points of manual intervention that payers typically automate. For example, in FBCS, claims clerks manually associate authorizations to claims (called distribution), batch claims for payment, and, for contracted claims and claims that should price at the billed charge, price claims.²⁴²
- For PC3 and claims that should price at the billed charge, the claim clerk needs to manually select the billed charge from a rate drop-down menu on the claim line.²⁴³ Manually working claims introduces errors and takes longer than processing claims automatically. Our finding is consistent with the 2010 OIG Report, which found that VA's system is too manual.

²³⁹ Per CBO Staff: VA Office of General Counsel (OGC) is reviewing whether "individual authorizations" meet the definition of a contract. If the determination is yes, this would mean "all" individual authorizations issued from individual VAMCs to providers would be a contract and would be applicable to prompt pay and interest payments. The previous OGC informal opinion was individual authorizations were not considered as contracts and did not meet the prompt pay requirements.

²⁴⁰ National Academy of Public Administration, Veterans Health Administration Fee Program, Report No. 2165, September 2011.

²⁴¹ Per 2014 IPERIA AUDIT REPORT NVC FINAL DRAFT 101414.docx and IPERA 2013 Exec Sum DRAFT v3.docx. These documents summarize VHA's annual review (internal) of Non-VA Care improper payments in accordance with IPERIA.

²⁴² Peter Kongstvedt "Essentials of Managed Care" Fifth Edition, 2007 Pg. 433-435 shows that it is common practice to have the following payment methodologies automated in the adjudication engine: Fee Schedule pricing, Capitations, Discounting, Per Diem pricing, Case Rates, Diagnosis Related Group (DRG) pricing, Ambulatory Surgical Codes (ASC) pricing. Pricing is not automated in FBCS as described as a best practice in this text.

²⁴³ Per Interviews/observations with four VAMCs

- We observed additional downstream technology processes for Non-VA Care that are highly manual. For example, we observed clerks rekeying or cutting and pasting data from one system to another as they created authorizations. Clerks then printed authorizations for future use in appointment follow-up.²⁴⁴
- All VAMCs that we visited and stakeholders at CBO reported the manual nature of VA's system negatively affected accuracy and timeliness.²⁴⁵ Payment accuracy and timeliness directly affects providers' satisfaction with payers. As mentioned earlier, untimely payment of claims "translates into provider dissatisfaction with possible degradation of the network." Degradation of the network means loss of providers in a network, which could directly affect patient access for Non-VA and VA Care. For patients, this equates to fewer options when seeking care and potentially longer wait times when locating providers accepting Veterans.

2. FBCS is not the claims system for all types of Non-VA Care.

- The inability to process all claims in a consistent manner prevents standardized processes, procedures and training from materializing. For example, Dental and Long Term Care (LTC) claims cannot be processed through FBCS.²⁴⁶ These claims require a much higher level of manual effort.²⁴⁷

Recommendations

- To address these findings, CBO should:
 - Develop and implement both a short-term and a long-term approach to reduce the degree of manual intervention in claims adjudication and other manual processes related to Non-VA Care business processes.
 - Prioritize in the short-term automation initiatives (presumably with FBCS). We understand VHA is enhancing FBCS to automatically reject duplicate claims—these will be the first Non-VA Care claims to go to a final status (e.g., Paid, Rejected, or Denied) without manual intervention.
 - Develop and implement a strategy to build or acquire a centralized, highly automated claims adjudication system. We recognize that VHA has initiated HCPS as the "centralized claims processing system that would help improve Non-VA provided care payment accuracy and claims processing timeliness."²⁴⁸ We also understand that this initiative is currently on hold because of findings from a recent OIG investigation.²⁴⁹ A

²⁴⁴ Per Interview/observation with the Philadelphia VAMC

²⁴⁵ Per Interviews with four VAMCs

²⁴⁶ Claims not processed through FBCS include: Dental, Adult day care, bowel and bladder, Home Health for contract nursing homes claims, and Dialysis

²⁴⁷ Claims processed in VistA take longer for staff to enter and process. These claims can only be billed on paper, and it takes a staff member longer to adjudicate a claim in VistA than in FBCS.

²⁴⁸ Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System
<http://www.va.gov/oig/pubs/VAOIG-14-00730-126.pdf>

²⁴⁹ Ibid.

centralized and highly automated system is integral for VHA to standardize the claims adjudication process across VAMCs and, in turn, improve payment accuracy and timeliness.

8.3.2 Non-VA Care Providers Do Not Have Visibility into the Status of Claims Due to a Lack of Online, Automated Tools.

Finding

1. Currently providers cannot determine the status of their claim online, which results in them rebilling the claim, creating additional workload for VHA.

- Online access to claims status allows providers to easily check the status of claims and determine, for example, if the claim is suspended and under review. With this online information, providers would be more likely to wait for claims resolution instead of resubmitting.
- Nearly all commercial plans allow providers to check claim status online. Some providers also support health care claims status request (formerly referred to as EDI Claim transaction set 276/277) and response.
- Payers support these methods because it allows providers to obtain claim status at their convenience, as well as decreasing demand on the provider call center. In contrast, for Non-VA Care, claims clerks perform this function through telephone communication.²⁵⁰ Allowing providers to check claim status online would lessen the workload of FBCS clerks, allowing them more time to process and resolve issues with incomplete claims, which should improve timeliness.

Recommendation

- CBO: Work with OIT to develop tools to provide the ability for providers to determine their claim status online. Transparency and convenience will lead to provider satisfaction and reduce the burden on the FBCS claims staff, which will increase claims payment timeliness. Providing online claim inquiry will reduce duplicate claims submitted by Non-VA Care providers that FBCS staff members must manually process, which will free them to pay claims more promptly. The approach should include the ability for providers to determine their claim status online. Transparency and convenience will lead to provider satisfaction and reduce the burden on the FBCS claims staff, which will increase claims payment timeliness. Providing online claim inquiry will reduce duplicate claims submitted by Non-VA Care providers that FBCS staff members must manually process, which will free them to pay claims more promptly.

²⁵⁰ Per Interviews/Observations with four VAMCs

8.3.3 The Rate of Electronic Claims Submission for Non-VA Care is Low.

Finding

1. Non-VA providers submit few electronic claims to VA, which negatively affects payment timeliness and accuracy.

- Non-VA Care providers submitted 28.6 percent of their claims electronically for fiscal year 2014.²⁵¹ A comparable benchmark for commercial payers shows that 94 percent of providers submit electronically.²⁵² High levels of paper claims affect accuracy and timeliness. Some Non-VA Care providers are reticent to submit EDI claims to VHA because there is significant confusion regarding VA's billing rules, particularly those related to electronic claims submission.²⁵³
- For VHA and other payers, processing paper claims requires additional steps relative to processing electronic claims. VHA calls these steps Scan, Upload, and Verify. The "Scan" process transforms the information on the paper document into data for FBCS. The "Upload" process brings the data into FBCS. During "Verify," claims clerks manually ensure that the Optical Character Recognition (OCR) process read the data correctly. These steps are similar for other private payers.
- Generally, the more a payer electronically automates claims processing, the cheaper and more reliably their systems operate. Most commercial and other government payers actively encourage their providers to submit all claims electronically. Providers submit electronic claims using a national standard format, the Electronic Data Interchange (EDI) format. These national EDI standards include:
 - 837I—this is the electronic format for institutional providers (replaces the UB-04)
 - 837P—this is the electronic format for physicians and other providers (replaces CMS-1500)
 - 837D—this is the electronic format for dental providers (replaces ADA form).
- Since all EDI claims are processed at a central location then routed to a VAMC based on the Zip Code in which the Veterans resides, a portion of EDI claims route to the incorrect VAMC for processing.²⁵⁴ This erroneous routing leads to delays in VHA paying claims and denials. Non-VA providers reported that they solve this issue through billing paper claims, which they manually route to the correct VAMC. One Non-VA Care provider stated that its facility initially bills all claims electronically. However, when VHA does not the claim processed within 45 days, it bills the same claim a second time through paper directly to

²⁵¹ Source: Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by VA informatics team.

²⁵² AHIP Center for Policy and Research: An Updated Survey of Health Insurance Claims Receipt and Processing Times, 2011, published February 2013.

²⁵³ Per Interviews with two VAMCs

²⁵⁴ Per Discussion with Minneapolis VAMC, providers submit all EDI claims to one location. Claims are translated and sent to VA closest to the member (distribution uses members' zip code). If the service did occur in that VA's area, the claim is routinely denied, even if an authorization exists at another VAMC. Note: This VAMC was selected as a positive deviant as a result of their ability to pay claims accurately and timely.

the “correct” VAMC. VHA now has a duplicate claim issue to address, which consumes staff resources and affects accuracy. The American National Standards Institute (ANSI), “Chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for inter-industry electronic exchange of business transactions-electronic data interchange (EDI).” This body created the 837 implementation guides referenced above. However, payers create 837 “companion guides” to assist providers with further instructions on billing electronic claims. For example, Medicare states that they publish companion guides to, “Clarify, supplement and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12,” implementation guides. Currently, VHA does not have a companion guide to provide additional guidance on electronic claims submission.²⁵⁵

- Processing claims electronically is less costly and more accurate than paper claims. Electronic claims also process faster.²⁵⁶

Recommendations

To address these findings, CBO should:

- Increase EDI claims submission rates by creating provider manuals, known in the industry as 837 companion guides,²⁵⁷ which will offer Non-VA Care providers the information they need to submit their claims electronically.
- Route EDI claims based on service authorization rather than Veteran Zip Code. VHA could use a “throw away”/currently unused EDI field to indicate the VAMC that issued the service authorization.
- Encourage, through contract provisions and preferential contacting approaches, Non-VA Care providers to submit electronic rather than paper claims.
- Create a provider portal so that providers can routinely check the status of submitted claims.
- Conduct outreach to providers submitting a large volume of paper claims, explaining billing rules and strongly encouraging electronic submission.

²⁵⁵ Per CBO Purchased Care Operations Directorate

²⁵⁶ Based on Navigant Consulting industry subject matter expertise

²⁵⁷ 837 is the EDI standard for claims submission. All claims must be submitted in the 837 format per the EDI implementation guide. 837 companion guides are designed to describe the network-specific business requirements, above and beyond those found in the HIPAA claims standards.

8.3.4 The Non-VA Care Claims Processing System is Not Centralized, Leading to Inconsistencies in Standardizing Claims Processing Across VAMCs.

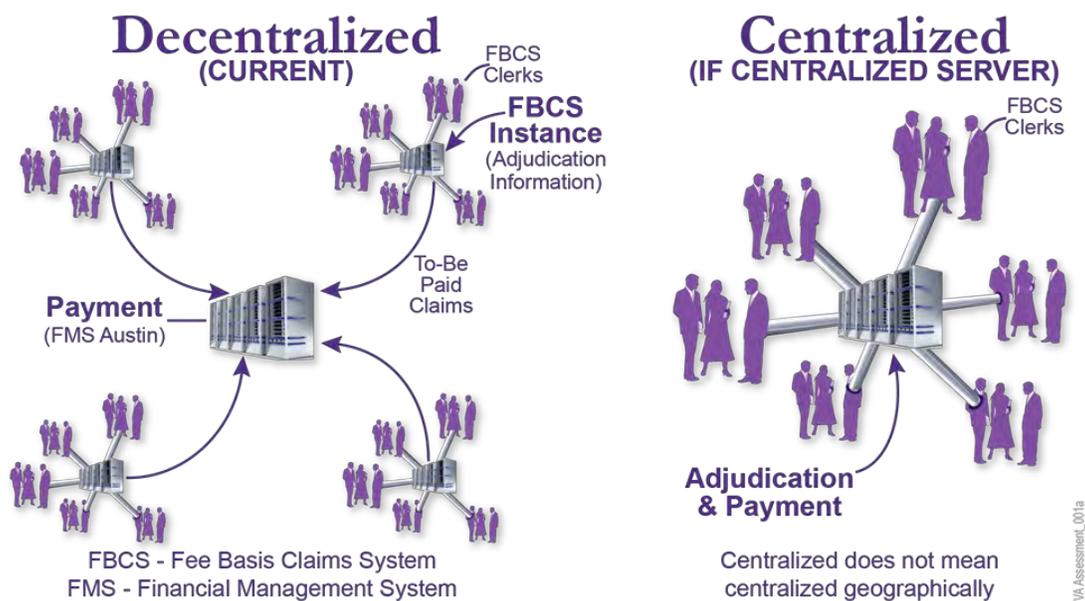
Findings

1. **There are discrepancies among deployed technical processes and local instances of FBCS, leading to inconsistent claims processing and the inability to establish keystroke-level training.**
 - The CBO training team commented that creating keystroke-level training is nearly impossible without a centralized system. Keystroke-level training describes the work steps required to perform a function keystroke by keystroke.
 - The 2013 and 2014 IPERIA reports cited VA's decentralized structure as a factor leading to inaccurate claims processing.²⁵⁸ Furthermore, two recent OIG reports recommended centralizing the Non-VA and VA Care claims processing system. In 2014, the OIG stated, "A centralized system will help with Mill Bill and unauthorized claims routing," while in 2010, the OIG stated:

"Efforts are needed to reduce the cost associated with processing claims and the time it takes to process claims by improving processing efficiencies. Inefficiencies occurred because of the Fee Program's decentralized structure and its labor-intensive payment system."
 - Figure 8-1 highlights the nature of decentralized versus centralized processing. Moving to a centralized processing model will allow VHA to standardize functionality, improving claims processing consistency, and reducing the resources required to maintain the systems.

²⁵⁸ Per 2014 IPERIA AUDIT REPORT NVC FINAL DRAFT 101414.docx and IPERA 2013 Exec Sum DRAFT v3.docx. These documents summarize VHA's annual review (internal) of Non-VA Care improper payments in accordance with IPERIA.

Figure 8-1. Decentralized Claims Processing System Inhibits Performance



Source: Grant Thornton’s rendition of VHA’s decentralized claims processing system

- Adding to the complexities of the decentralized Non-VA Care claims processing, some VAMCs run FBCS at their facilities; other VAMCs partner with VISNs; and others consolidate multiple VAMCs into a ‘Consolidated Fee Unit’ to process claims. For example, Philadelphia, part of VISN 4, processes a portion of its claims on-site, while all of VISN 19 claims process in one location. FBCS processes all Non-VA Care claims on one of 34 servers located across the nation, and each server represents a separate instance of FBCS.

Table 8-2. FBCS Server and Use Summary

Number of VAMCS using FBCS ²⁵⁹	Number of locations processing claims ²⁶⁰	Number of FBCS servers ²⁶¹
150	88	34

- VHA can deny Non-VA Care claims due to misrouting of claims. This can happen as another consequence of the decentralized claims processing system, and is an issue that angers and frustrates Veterans, according to interviews with VAMC personnel. Claims may route to a VAMC that did not create the authorization because a decentralized system

²⁵⁹ The Manila VAMC does not use FBCS

²⁶⁰ Per CBO Purchase Care Operations Directorate

²⁶¹ Per CBO Non-VA Care Way Forward Directorate

cannot reroute a claim to the correct VAMC.^{262,263} Clerks do not always check other VAMCs for authorizations, and so they deny claims in cases where both the Veteran and provider were assured the services were approved for payment. In these cases, VHA sends a letter to the provider and Veteran communicating that the services are not reimbursable through VA, instructing the provider to seek reimbursement from the Veteran. This leads to extreme dissatisfaction on behalf of the Veteran and the provider. In a centralized system, all authorizations are in the same system, which will reduce these denial errors dramatically.

Recommendations

- CBO: Develop keystroke-level training for staff with clear and complete billing instructions for Non-VA Care providers with the implementation of a centralized, highly automated claims processing system.
- CBO: Centralize all claims processing functions to create standardization. The October 2014 organizational consolidation of claims processing will benefit the development and implementation of standards around processes, adoption of policies and use of technology.
 - We recognize CBO is in process of centralizing oversight of claims processing across five regions. A five-region approach should result in better performance and outcomes, similar to the MACs supporting CMS. This is a step in the right direction. In addition to consolidating leadership, VHA should consolidate the requisite staff members to support the centralization of a highly automated claims processing system. Additionally, a centrally deployed claims system will support standardization and uniform claims processing across business functions and geographically dispersed areas. VHA will also reap the benefits of standardized staff training and stronger internal controls.
- CBO/VHA: Resolve the funding issues that preclude the implementation of HCPS as the “centralized claims processing system that would help improve Non-VA provided care payment accuracy and claims processing timeliness.”²⁶⁴ We understand that this initiative is currently on hold as a result of findings from a recent OIG investigation.²⁶⁵ Rectifying the issue is integral for VHA to standardize the claims adjudication process across VAMCs will improve payment accuracy and timeliness.

²⁶² Claims can be misrouted as the result of the EDI process or because the provider billed a paper claim to a VAMC that did not create the authorization.

²⁶³ Per Minneapolis VAMC, clerks frequently deny claims for authorized services when the claim is misrouted to a VAMC that did not authorize the care. Theoretically, clerks can search for authorizations from other VAMCs on the same FBCS server, but more commonly, these are denied. This question was asked to staff at VISN 8 and Salt Lake City who confirm that this was a common problem across VHA.

²⁶⁴ Review of Alleged Misuse of VA Funds To Develop the Health Care Claims Processing System
<http://www.va.gov/oig/pubs/VAOIG-14-00730-126.pdf>

²⁶⁵ Ibid.

8.4 Information Technology Summary of Findings

The following table summarizes the findings and recommendations presented in this chapter, providing further detail to identify each finding’s significance and each associated recommendation’s timeline and effect.

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
VA Care				
Inadequate technology prevents effective Veteran education, delays Veteran payment plans and delays Veteran co-payment collection	VHA should invest in tools, technology, and/or functionality that will allow staff to provide patients with real-time estimate of out-of-pocket expenses	Tier 1	Short	People, Process, Technology
Significant limitations in the integration of tools and functions across clinical and revenue management systems increase collection delays and denials	VHA should prioritize the integration of tools (and functions) across patient intake, clinical administration, and billing systems. In particular, we recommend VA to integrate medical records, coding, and billing systems with single sign-on to facilitate expedited claims generation and payment.	Tier 1	Medium	People, Process, Technology

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
VHA Billing staff are manually reviewing 100 percent of claims subsequent to automated claim edits, resulting in significant workload and affecting billing timeliness	Prioritize funding and accelerate planning efforts to integrate a patient accounting system that includes automated billing that will support algorithmic edits and where appropriate, automate correction of claims to minimize manual review requirements.	Tier 1	Medium	People, Process, Technology
Lack of automation for Non-VA Care Claims processing (via FBCS) delays payments, causes inaccuracies, and increases improper payments.	Develop and implement both a short-term and a long-term approach to reduce the degree of manual intervention in claims. Prioritize in the short-term automation initiatives (presumably with FBCS). Develop and implement a strategy to build or acquire a centralized, highly automated claims adjudication system.	Tier 1	Short	Technology
Non-VA Care Providers Do Not Have Visibility into the Status of Claims Due to a Lack of Online, Automated Tools	Invest in technology solution to provide the ability for providers to determine their claim status online.	Tier 2	Medium	Technology

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
The rate of electronic claims submission for Non-VA Care is low	Increase EDI claims submission rates by creating provider manuals	Tier 2	Medium	Technology
The Non-VA Care claims processing system is not centralized, leading to inconsistencies in standardizing claims processing across VAMCs	Centralize all claims processing functions to create standardization.	Tier 2	Medium	Technology
<p>Legend</p> <p>Significance Tier 1 = Direct effect to payment and billing timeliness and accuracy Tier 2 = Supporting actions to improve payment and/or billing timeliness and accuracy</p> <p>Timeline Short Term=0-2 years, Medium=3-4 years, Long Term=>4 years</p> <p>Impacts People Process Technology</p>				

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

This page intentionally left blank.

9 Analysis of Oversight and Metrics—VHA Lacks Certain Performance Reporting to Provide Effective Oversight and Proactive Process Improvements for Collections and Payments.

9.1 Introduction

As described in Chapter 6, to better support VA Care operations, all VAMCs have transitioned their Patient Accounting operations to one of the seven CPACs. The transition to the CPAC structure drove standardization and coordination across Patient Accounting functions. VHA placed the CPACs under the Central Business Operations (CBO) agency. Today, VAMCs execute the “front-end” (Patient Intake and Clinical Administration) operations, and the CPACs, perform “back-end” (billing and accounts management) operations.

Chapter 7 describes the role of the CBO Purchased Care organization and their responsibilities for the development of administrative processes, policy, regulations and directives associated with the delivery of the Non-VA Care program. CBO is now responsible for all claims processing and payment operations and staff. Supervisors and claims clerks manage and conduct the day-to-day activities of the Non-VA Care program. These activities include scanning claims, reviewing administrative eligibility, processing claims for payment, answering Non-VA provider inquiries.

The findings and recommendations below address opportunities to benefit from stronger national reporting, leveraging private-sector benchmarks, more insightful decision support, common productivity standards, and management over interest payments. The findings also address program integrity tools, an area where VHA is realizing results and should continue momentum with additional automation initiatives.

9.2 VHA Medical Care—Revenue

Finding

1.VHA lacks standard national reporting of key performance metrics for timely insurance identification and verification across VHA, inhibiting visibility into insurance capture performance of VAMCs.

- Insufficient national reporting on Patient Intake key performance metrics hinders visibility into the Patient Intake functions of VAMCs and contributes to lack of accountability by all responsible parties.²⁶⁶

²⁶⁶ Qualitative interviews at four VAMCs.

- VAMCs maintain some Patient Intake metrics (e.g., the insurance capture buffer error rate that identifies missed insurance capture opportunities at check-in) and reports to Compliance and/or the VISN; however, this reporting is not standard or published on a national scale.²⁶⁷

Recommendations

- VHA: Create a Patient Intake national reporting platform and centralized database to monitor key Patient Intake performance metrics that include:
 - Scheduling rate
 - Pre-registration rate of scheduled patients
 - Insurance verification rate of scheduled patients
 - Insurance verification rate of pre-registered patients
 - Insurance verification rate of unscheduled patients within one business day
- Leverage existing VHA Support Service Center platform to improve monitoring. This platform includes the nationally reported HIMS metrics in addition to Compliance and Business Integrity (CBI) metrics.
- Enhance reporting and monitoring of key Patient Intake performance metrics by requiring VAMCs to report the key Patient Intake performance metrics listed above on a monthly basis. This enterprise system would provide leadership at the VAMC, VISN, CPAC, and CBO with insight into key areas for improvement as well as to develop resolutions to ensure that third-party insurance is identified and verified prior to a service performed at least monthly.

Finding

2.Reporting in the current patient accounting system (VistA) is not comparable to the private sector, inhibiting the identification of areas for improvement.

- AR shows the amounts owed to VHA by third-party insurers. Aged AR reflects amounts owed by the length of time the balance has been outstanding. These are standard metrics used to assess performance in the private sector.
- However, interviews with CPAC staff and CBO leadership revealed that aged AR is not tracked the same way as private sector, preventing qualified insight into performance. VA tracks third-party AR greater than 90 days against a standard of less than 18 percent and were able to achieve this goal every month in 2014.²⁶⁸ VA's AR metric calculation starts at the date of the most recent bill (which includes rebills) rather than the date of encounter or original bill date.

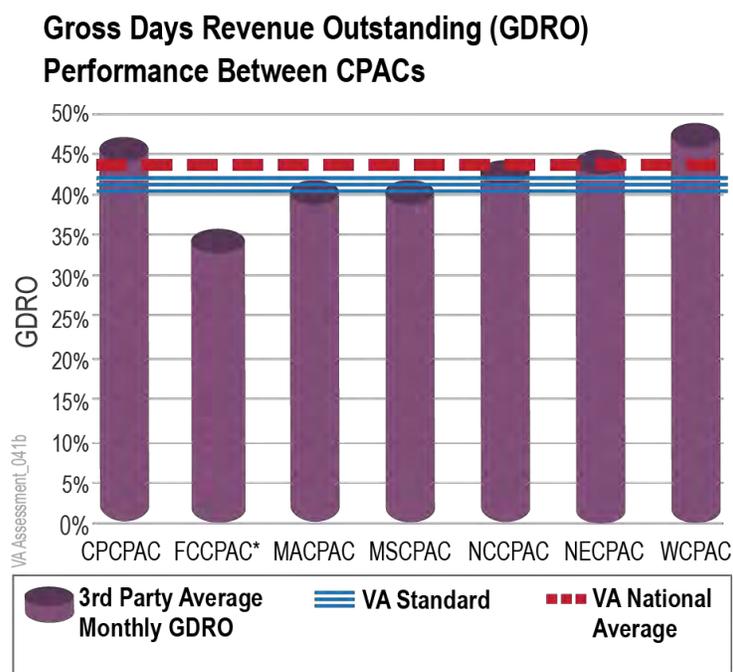
²⁶⁷Qualitative interviews at four VAMCs.

²⁶⁸CBO Revenue Cycle Performance Metrics Panel for Fiscal Year 2015.

- The result of this reporting is that the age of AR reported by VHA is significantly skewed and reported as more favorable than would be the case in the private sector.²⁶⁹ This presents a risk to VHA's ability to collect third-party insurance balances due, since they are unable to obtain a more refined and accurate snapshot of the age of VA's outstanding AR. In addition the follow up teams are working from an AR aging that does not reflect the most appropriate age of the account.
- VHA defines GDRO as the average number of days for a third party to pay a bill. VHA calculates GDRO by taking aged AR (excluding unbilled accounts) divided by the billings of the previous three months, divided by the number of days in the previous three months. This metric allows VHA to assess the timeliness of the CPAC's third-party collections. VHA's standard for GDRO is 43 days, displayed in Figure 9-1, and some VHA CPAC's are achieving this metric while others are not. The industry best practice benchmark of net days in AR (net AR divided by average daily net revenue) is 55 days or less. Net GDRO accounts for contractual and other adjustments made to gross patient revenue.
- The manner in which VHA calculates GDRO is unique and not comparable to the private sector. The private sector calculates GDRO by including unbilled and billed AR amounts and utilizing both gross and net revenue. VHA calculates GDRO by excluding unbilled AR amounts because some amounts relate to non-billable service connected care. In addition, GDRO as calculated by VHA uses gross billings as opposed to net revenue. Figure 9-1 shows the gross days revenue that are outstanding for CY 2014.

²⁶⁹Qualitative interviews at one CPAC indicated that this was an issue.

Figure 9-1. Gross Days Revenue Outstanding – CY2014²⁷⁰



Source: CPAC GDRO Performance from CBO, CY2014

Note: San Juan is excluded from FCCPAC analysis due to unique payers not on electronic billing.

Recommendations

- Create a Patient Intake national reporting platform and centralized database to monitor key Patient Intake performance metrics such as: scheduling rate, pre-registration rate of scheduled patients, insurance verification rate of scheduled patients, insurance verification rate of pre-registered patients, and insurance verification rate of unscheduled patients within one business day. Reporting should be completed on a monthly basis to provide leadership at the VAMC, VISN, CPAC, and CBO with insight into areas for improvement.
- Evaluate the current reporting capabilities of the patient accounting system and perform a gap analysis with equitable private sector reports. Specifically for AR, VA should adjust the tracking and reporting of aged AR to match leading practices in the private sector. This would further enhance VA's ability to identify the root causes for process improvement areas and knowledge from which to develop and act on resolution plans.

²⁷⁰CBO. (2015). *Average Monthly GDRO for Third Party, CY2014*. Retrieved from POWER and reported in POWER by CPAC. The figure above displays VA nationwide GDRO in comparison to VA target of 43 days for CY2014, and CY2014 performance with national average 43.2. San Juan is excluded from FCCPAC analysis due to unique payers not on electronic billing.

Finding

3. Ineffective payer contracting at the regional level negatively affects oversight and standardization from VHA's Revenue Operations Payer Relations Office.

- Contracts are the foundation for payment for applicable payers, and VHA needs to be paid competitive rates and correctly. CBO has established national contracts with large payers as managed by the Revenue Operations Payer Relations Office. Each CPAC manages their own regional contracts, with guidance provided by the Revenue Operations Payer Relations Office only on an 'as-needed' basis. This arrangement limits the opportunity for local regional contracts to reap the benefits and negotiating strengths of the Revenue Operations Payer Relations Office.²⁷¹
- Standardization across regional payers may be an opportunity for CBO to increase collections. It is common that a CPAC could have several regional contracts and several national contracts with payers. For regional contracts, we recognize that the Revenue Operations Payer Relations Office affords the CPAC access to a national support service that will perform background analysis on the regional payer, including reimbursement rates. Although the Revenue Operations Payer Relations Office provides guidance, the CPAC Payer Relations Department is ultimately responsible for contract negotiations with the regional payer. Further, during our interviews it was reported that CPACs may not have sufficient FTE funding or available legal resources to appropriately negotiate with regional payers, which adds to the risk of sub-optimal rates.
- During our interviews, it was indicated that it takes an inordinate amount of time (several months) for a CPAC Payer Relations Department to establish a new payer contract. This length of time may prevent VHA from receiving appropriate reimbursement for services while a contract is not in place. This may also affect collection efforts, decreasing cash flow and reducing realized revenue. In these instances (with payers without contracts), VHA accepts any payment from these regional payers. Without disciplined payer contracting in place at the regional level, loss of revenue may occur, directly affecting the collection of amounts owed to VHA for care provided.

Recommendations

- CPAC Payer Relations staff should report to the Revenue Operations Payer Relations Office. Doing so should allow VHA to have better leverage with payers and achieve better economies of scale. This should further optimize reimbursement rates and further support VHA's continuous improvement efforts. A standardized approach should allow for flexibility at the CPAC/regional level, while addressing issues promptly with national leverage, particularly payer negotiations. Payer Relations staff should remain co-located at the CPAC to better understand regional influences, maintain a local presence, and resolve local issues such as shortages of key specialties or provider types (e.g., nursing homes).

²⁷¹Qualitative interviews at three CPACs indicated that this was an issue.

- The Revenue Operations Payer Relations Office should create payer scorecards to gain insight into payer reimbursement and further optimize VHA’s relationship with payers. Internal payer scorecards should be built with adjudication analytics in place, including claims/dollars denied by payer, cost to collect, etc., to help support contract negotiations. Scorecards should help provide transparency into the relationships between negotiated rates and the cost of care.

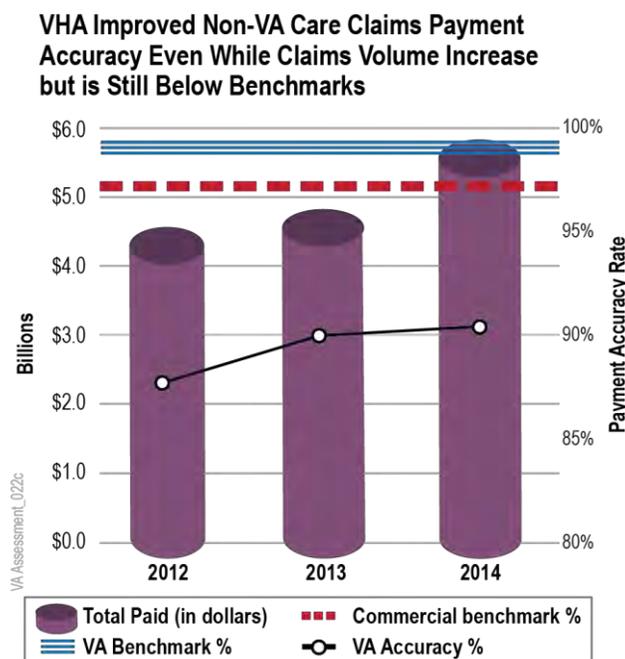
9.3 Non-VA Care—Payment

Finding

1.VHA implemented additional oversight mechanisms to increase payment accuracy, leveraging the Program Integrity Tool (PIT) and Quality Inspector Tool (QIT), to improve payment accuracy.

- VHA introduced PIT and QIT to identify inaccurately processed claims prior to payment. During the last three years, accuracy improved while the total claims paid has increased. Increasing claims volume puts additional strain on staff and system resources. Generally, increasing claims load would have a negative effect on accuracy performance; however, VHA improved its accuracy numbers while also accepting a higher claims volume.

Figure 9-2. Claims Paid Volume and Accuracy²⁷²



Source: Paid Data and Timeliness FY12-FY14 Data

- All inaccurate payments negatively affect the payer and the provider, because they create additional administrative work for both parties. Inaccurate payments can also lead to

²⁷² Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics

misdistribution of funds. When payers overpay providers, payers must coordinate with providers to recoup the overpayments. Underpayments cause provider dissatisfaction. When there are duplicate payments, the payer pays twice for a service only rendered once.

Recommendation

- Continue developing technical solutions, such as QIT and PIT, which catch claims processing errors before making payments. While QIT and PIT are good tools to track payment accuracy, over reliance on these tools will result in needless additional costs and workload. We understand VHA is working to add additional rules into PIT, and this should be a continuous process. For example, VHA is working to implement rules from the QIT process into PIT. Because not every VAMC uses QIT, this will promote running the QIT checks on all claims. VHA should also continue to build additional rules into PIT (to supplement rules not coded in FBCS) to further improve payment accuracy.

Finding

2. Current decision support capabilities are not sufficient to support oversight and management of Non-VA Care claims processing and payment.

Decision support or business intelligence systems are uses of technology that allows organizations to analyze their data effectively. Decision support systems play a key role in “data warehousing, security, standard and ad hoc analytics, care and disease management, fraud and abuse detection, other-party liability administration, and financial functions such as forecasting and reporting.”²⁷³ Leaders depend upon data to make informed financial and clinical decisions. Lack of reliable and complete data impairs leaders’ abilities to analyze their health care delivery systems properly, regarding appropriateness and quality of care, financial management, and all aspects of operations.

Leading health insurer practices involve “[extracting] and [manipulating] key elements...to make virtually all data elements reportable so that [payer] analysts can include any number of factors in business and health care improvement needs.”²⁷⁴ For example, insurers routinely use reports to track trends and patterns in denied or pended claims to identify potential root causes. They also use reports to identify patterns in claims volume over time, so that they can deploy appropriate numbers of staff to work through anticipated claims backlog, staff provider services hotlines or conduct provider outreach.

CBO performs most of the decision support analysis for VHA for Non-VA Care claims. When VHA leadership needs reporting on clinical or financial metrics, the CBO Department of Informatics creates the reports primarily using data from paid claims processed through FBCS and VistA. Our team worked with the Department of Informatics to extract data related to Non-VA Care.

²⁷³ Peter Kongstvedt “Essentials of Managed Care” Fifth Edition, 2007 Pg. 398

²⁷⁴ Ibid

Our team also reviewed OIG reports related to VA’s decision support systems and interviewed Informatics staff.

- The analytical deficiencies across claims processing and payment prevent VHA from effectively assessing the performance of and management of the processing system. For example, VHA is not able to determine the reasons for denial or suspense of claims. Due to this deficiency, VHA is unable to analyze enterprise-wide denials.²⁷⁵
- Another example is VHA’s inability to load critical information into CBO decision support system. For example, the current decision support system cannot accurately report on the number of claims paid, since decision support system does not maintain the internal control number assigned to claims. VHA staff members do not load denied and rejected claims into the decision support system. These denied claims data is available only at the local level. As a result, CBO stated that retrieving denied claims data would be a lengthy and involved process. Additionally, CBO cannot identify or stratify Millennium Bill (referred to as Mill Bill – which as specific subset of requirements) from unauthorized claims for reporting purposes.²⁷⁶
- Without a robust decision support system, VHA analysts have limited capabilities to report on trends to executives, clinical and financial staff. Since VHA is not equipped to identify high frequency or common denials across the system, VHA cannot identify geographic areas or topics to focus provider outreach on. VHA cannot achieve valuable insights (e.g., transparency into the largest billers of paper claims) through the current decision support system.²⁷⁷
- The decision support system does not contain fields for commonly used data fields, such as “claim form type” (e.g., UB-04, CMS-1500, etc.), which are helpful for analyses. It does not receive the “claim form type” field from FBCS. VHA needs additional fields to enable analyses that drill into the root causes for interest and penalties. A more robust decision support system may also assist with care management and care coordination processes.²⁷⁸

Recommendations

- Retain more information from claims processing in VHA’s decision support system and develop more comprehensive reports for Non-VA Care management. VHA should retain and load all denied and rejected claims into the decision support system.²⁷⁹ Making this additional information available to the staff will allow them to conduct more robust analysis to drive provider outreach, reducing the rate and frequency of denials.

²⁷⁵ Based on Interview with CBO Informatics and industry subject matter experts

²⁷⁶ Based on Interview with CBO Informatics and industry subject matter experts

²⁷⁷ Ibid.

²⁷⁸ Ibid.

²⁷⁹ CBO reported that taking steps to retain and load this information is on its roadmap.

Consequently, VHA can lessen the workload of the clerks, which will also improve payment timeliness.

- Use the decision support system to inform VHA's training programs for claims processing staff by identifying claims processing protocols that are not applied consistently by staff. Leading practice is to use it to identify error rates and patterns across individual staff members to inform training plan development.

Finding

3.VHA cannot establish productivity standards and monitor employee performance because its processes are not consistent across VAMCs and VISNs.

- For example, some VAMCs appear to have the claims clerks work closely with the authorization personnel and involved in care coordination, while others do not. Some claims clerks are more involved in "provider relations" activities than are others. Additionally, claims clerks work on all types of claims that require varying levels of effort. Some claims clerks process only authorized claims while others work both authorized and unauthorized. In some cases, even outpatient and inpatient claims are divided among claims staff. In the private sector, claims clerks have uniform responsibilities resulting in better outcomes.²⁸⁰
- The inconsistency extends beyond processes and procedures to department naming conventions. From facility to facility, the same departments often have varying names and position descriptions, leading to Non-VA provider confusion. For example, at a sample of four VAMCs, the authorization and scheduling department for Non-VA Care is referred to using four different names: Patient Administration Services (PAS), Health Administration Services (HAS), Business Service, and Non-VA Care Coordination.²⁸¹

Recommendation

- Establish VHA-wide productivity standards for staff. VHA should employ these standards to project staffing needs and evaluate staff performance to assure sufficient staff to support the claims processing process. As Non-VA Care continues to evolve, continually assessing VHA staffing levels is critical in leveraging human resources necessary to improve the accuracy and timeliness of claims processing. We understand CBO is assessing staffing levels across Non-VA Care. CBO will use these studies to identify production standards across all VAMCs and evaluate staffing to support achievement of the standards. The study is scheduled to complete in June 2015.²⁸² Productivity standards and staffing projections should account for the future influence of technology.

²⁸⁰ Per Interviews with four VAMCs

²⁸¹ Per site visits to four VAMCs

²⁸² Per Interviews with CBO Purchased Care

Finding

4.VHA does not conduct sufficient management and oversight activities to understand, manage, and prevent interest penalties paid to Non-VA providers.

- This finding addresses oversight activities; Chapter 7 covers Non-VA Care in detail. We cross-reference it here to highlight that a critical component of the findings and recommendations supporting interest penalties is oversight across the VHA management team. We found a lack of awareness and transparency of information of interest penalties at the VAMC level. Reducing the risk of interest penalties requires coordinated and clear definition of roles and responsibilities for oversight and execution of interest penalty management.²⁸³

9.4 Summary of Findings and Recommendations

The following table summarizes the findings and recommendations presented in this chapter, providing further detail to identify each finding’s significance and each associated recommendation’s timeline and effect.

Table 9-1. Summary of Findings and Recommendations

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
VHA implemented additional oversight mechanisms to increase payment accuracy, leveraging the Program Integrity Tool (PIT) and Quality Inspector Tool (QIT), to improve payment accuracy	Continue developing technical solutions, such as QIT and PIT, which catch claims processing errors before payments are made	Tier 1	Short	Process, Technology
Current decision support capabilities are not sufficient to support oversight and management of Non-VA Care claims processing and payment	Retain more information from claims processing in VA’s decision support system and develop more robust reports for management of Non-VA Care	Tier 1	Short	Process, Technology
VHA does not conduct sufficient management and oversight activities	Establish transparent reporting of interest at the facility level and	Tier 1	Short	People, Process, Technology

²⁸³ Per Interviews with four VAMCs

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
to understand, manage, and prevent interest penalties paid to Non-VA providers	establish stronger coordination between national and VAMC level management over interest penalties			
VHA lacks standard national reporting of key performance metrics for timely insurance identification and verification across VHA, inhibiting visibility into insurance capture performance of VAMCs	Create a Patient Intake national reporting platform and centralized database to monitor key Patient Intake performance metrics	Tier 2	Short	People, Process, Technology
Reporting in the current patient accounting system (VistA) is not comparable to private sector, inhibiting the identification of areas for improvement	Create a Patient Intake national reporting platform and centralized database to monitor key Patient Intake performance metrics	Tier 2	Medium	People, Process, Technology
VHA cannot establish productivity standards and monitor employee performance because its processes are not consistent across VAMCs and VISNs	Establish VA-wide productivity standards for staff	Tier 2	Short	Process, Technology
Ineffective payer contracting at the regional level negatively affects oversight and standardization from VHA's Revenue Operations Payer Relations Office	CPAC Payer Relations staff should report to the Revenue Operations Payer Relations Office The Revenue Operations Payer Relations Office should create payer scorecards to gain insight into payer reimbursement and further optimize VHA's	Tier 2	Short	People, Process, Technology

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

FINDINGS	RECOMMENDATIONS	SIGNIFICANCE	TIMELINE	IMPACT
	relationship with payers			
<p>Legend</p> <p>Significance Tier 1 = Direct effect to payment and billing timeliness and accuracy Tier 2 = Supporting actions to improve payment and/or billing timeliness and accuracy</p> <p>Timeline Short Term=0-2 years, Medium=3-4 years, Long Term=>4 years</p> <p>Impacts People Process Technology</p>				

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

10 Conclusion

Strengthened business processes provide VHA with significant opportunity to improve the financial viability of VA. We recognize VHA has made notable improvements across both revenue and payment processes in recent years. Synchronizing people, process, and technology is critical for VHA to continue improvements to increase collections and pay claims timely and accurately. As transformation efforts take place, consistent messaging from VHA leadership supported by ongoing organizational change management around business processes is essential for any strategy to succeed. Both Veterans and VHA staff members need to be included in planning and decision-making. During site visits for this assessment, we were routinely impressed with the commitment and resolve of VHA staff members. VHA leaders need to harness this energy by educating, stimulating, and guiding staff members through business process challenges, tying performance to positive outcomes for Veterans. The resulting empowerment will allow VHA to reap the benefits of a rich and mission focused culture.

The recommendations in this report focus on culture, as well as process and system improvements. The standardization and alignment of performance metrics, simplification of rules, and effective communication offer tremendous upside that is currently lacking in business processes. Adopting the recommendations in this report will allow VHA to improve business process performance, and increase satisfaction for both VHA staff members and the Veterans they serve.

This page intentionally left blank.

Appendix A Background Information

A.1 VA Care, Revenue

A.1.1 Denials

Table A-1 provides the denial categories, definitions, corrective actions with our corresponding recommendations to correct the business processes, per each denial category. The last column references the section of this report that addressing the issue.

Table A-1. Denial Categories and Recommendations

Denial Category	Definition	Corrective Action	Revenue Cycle Business Process	Controllable or Uncontrollable	Recommendation	Report Section
Authorization Issue	Denied claim for service without pre-authorization	1st: Complete Pre-Auth at Time of Scheduling and/or prior to service; 2nd: Revenue Utilization Review (RUR) Nurse/ Follow-Up	Patient Intake	Controllable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification.	See section 6.3.2
Coverage Period Termed	Denied for invalid insurance coverage at time of service	Verify coverage prior to providing services; patient executes a document indicating it is the patient's responsibility if their insurance is denied	Patient Intake	Controllable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification.	See section 6.3.2

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Denial Category	Definition	Corrective Action	Revenue Cycle Business Process	Controllable or Uncontrollable	Recommendation	Report Section
Coordination of Benefits	Billed incorrect insurance or billed multiple insurance carriers in the incorrect sequence.	Verify insurance and determine primary and secondary carriers so that claims are submitted properly	Patient Intake	Primarily Controllable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification.	See section 6.3.2
Maximum Benefit	Maximum coverage benefits reached. Insurance will not reimburse for services rendered.	Verify coverage prior to rendering services.	Patient Intake	Controllable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification.	See section 6.3.2
Non-Covered Charge	Denied as service charge is not covered by insurance carrier.	Verify coverage prior to rendering services. Timely updates to charge description master.	Patient Intake and Clinical Administration	Controllable/ Uncontrollable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification. Timely update of charge description master.	See sections 6.3.2, 6.3.3
Patient Eligibility	Patient not covered by insurance when services provided.	Verify coverage prior to rendering services.	Patient Intake	Controllable	Enhance Insurance Identification at Scheduling and Pre-Registration to enable Insurance Verification in advance of visit. Continue enhancement of electronic insurance verification tool and of automation and control improvements with Kiosks to support Insurance Identification and Verification.	See section 6.3.2

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Denial Category	Definition	Corrective Action	Revenue Cycle Business Process	Controllable or Uncontrollable	Recommendation	Report Section
Medical Necessity	Denied as the procedure was deemed not medically necessary by the third-party payer.	Submit clinical and other information supporting provision of services, contract negotiation, and verify coverage for specific services	Clinical Administration/ Patient Accounting	Controllable	CDI role and initiative.	See section 6.3.2, 6.3.3
Wrong Procedure Code	Denied claim due to system/coding issues	Incorrect code; Need coder training or update to code in Nuance	Clinical Administration	Controllable	Coder training and certified coders, effective updating and management of charge description master.	See section 6.3.3
Duplicate Claim	Denied for duplicate billing	Root cause analysis to identify reasons for duplicate submission. Timely resolution of the initial denial received.	Patient Accounting	Controllable	Account management and Billing education and timely resolution of initial denials as received.	See section 6.3.4
File Limit Expired	Denied for untimely submission of claim to payer	Identification and verification of correct payer prior to providing services, timely coding of accounts and submission of claim within payer guidelines. Contracts with filing times VHA can meet.	Patient Accounting, Clinical Administration and Patient Intake	Controllable	Conduct root cause analysis of key reasons for untimely submission. Develop corrective action plans based on findings.	See section 6.3.2, 6.3.3, 6.3.4

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Denial Category	Definition	Corrective Action	Revenue Cycle Business Process	Controllable or Uncontrollable	Recommendation	Report Section
Information Requested	Payer denied claim and is requesting additional information related to services provided.	Respond to information as requested by payer	Patient Accounting coordination with Patient Intake and Clinical Administration	Uncontrollable	Primarily uncontrollable. Send required information that is known when claims are submitted.	N/A

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

A.1.2 Insurance Verification

Insurance verification process standards include obtaining patient dates of eligibility, service coverage, and pre-certification/authorization requirements from a patient's third-party insurance carrier. VA staff should verify all third-party insurance benefits prior to providing scheduled services to a patient or immediately after providing services related to emergent care. Disciplined insurance verification allows for billing of amounts due to the appropriate third-party carriers and obtaining pre-authorization information, as required. These efforts typically increase overall cash collections and increase net revenue by reducing third-party denials.

Private sector insurance verification processes frequently occur when an appointment is scheduled or during pre-registration procedures. For emergency cases, insurance verification should occur upon the completion of services and/or initial stabilization of the patient. Leading practices are to verify insurance benefits and coverage for all scheduled inpatients within 72 hours prior of the date of service. During this process, VHA validates dates of eligibility, service coverage rules, and pre-certification/authorization requirements.

We assessed VHA insurance verification performance by conducting site visits to multiple CPACs and VAMCs and by collecting VAMC insurance identification data via a national data call. During the VAMC site visits, we held interviews with the patient administration staff that requests third-party insurance information from patients during the check-in process. During the CPAC site visits, we also held interviews with staff at the CPAC who process the insurance information captured by the Patient Check-In clerks at the VAMCs. Additional assessment activities included observing the insurance capture buffer (ICB) tool used by VHA (a tool that signals Patient Check-In clerks which patient's third-party insurance information needs to be identified and captured at 'check-in'). Our team also reviewed the amount spent annually on outside contractors to perform additional insurance verification procedures. We evaluated VHA insurance capture performance metrics. Facilities and clinics are accountable to these performance metrics. Our team also reviewed OIG reports related to billing for VHA-provided care.

Current State

Current Organizational Structure

Key VA components and employees across the organization administer the revenue cycle process. Roles and responsibilities described below highlight respective organization functions that facilitate coordination of care for the Veteran as well as collections:

- **VHA's Office of the Chief Financial Officer (CFO):** The Office of the CFO at VHA is responsible for establishing financial management and accounting policies and procedures, monitoring financial activity, and monitoring compliance with fiscal policy.
- **Chief Business Office (CBO):** Located in Washington, DC, CBO is responsible for providing national leadership for advancing business practices that support patient care and delivery of health benefits. This group is responsible for ensuring that activities associated with the generation and management of revenue-cycle activities related to medical care comply with business standards and requirements, including implementing appropriate internal controls

Assessment I (Business Processes)

and performance measures. The CPACs, as well as the Health Eligibility Center (HEC) and the Health Resource Center (HRC), are under the guidance of the CBO.

- **Financial Services Center (FSC):** Located in Austin, TX, the FSC has direct involvement in many of the key-business processes for VA's financial reporting and the medical-care revenue cycle, such as completing first and third-party payment transactions.
- **Health Eligibility Center (HEC):** Located in Atlanta, GA the HEC supports VA's health care delivery system by providing centralized eligibility verification and enrollment processing services. The HEC verifies income reported by patients on the 10-10EZ (Application for Health Benefits) and 10-10EZR (Health Benefits Renewal Form) applications used for determining eligibility. HEC uses the Income Verification Matching (IVM) process to verify Veteran's—self-reported income information by computer matching with the Social Security Administration (SSA) and the Internal Revenue System (IRS).
- **Health Resources Center (HRC):** Located in Topeka, KS, the HRC is responsible for the Health Benefits Call Center (HBCC) and the First Party Call Center (FPCC). The HBCC is responsible for updating Veterans' profile information, such as address changes and contact information, and then transmitting these updates to the HEC. The FPCC responds to inquiries from Veterans who have questions regarding co-payments, as well as questions regarding medication, hardship waivers, and repayment plans.
- **Austin Information Technology Center (AITC):** Located in Austin, TX, the AITC is responsible for providing automated data processing support for medical reimbursement activities to all VAMCs. AITC is responsible for accumulating the data used for the allocation of Veterans Equitable Resource Allocation (VERA) funds. VERA is the primary methodology that VA uses to distribute resources based upon historical workload and utilization of services by Veterans.
- **Consolidated Patient Account Centers (CPAC):** Located in seven regional offices throughout the country, CPACs centralize the traditional VHA accounting functions focused on the back-end of the revenue cycle process. The purpose of the CPAC system is to “[re]engineer and integrate all business processes of the revenue cycle of the Department. CPACs standardize and coordinate all activities of the Department related to the revenue cycle for all health care services furnished to Veterans for non-service-connected medical conditions. They apply commercial industry standards for measures of access, timeliness, and performance metrics with respect to revenue enhancement of the Department.”²⁸⁴ The CPACs take the coded encounters from the VAMCs, generate the patient bills, and work with Veterans and third-part insurance carriers to collect and process payments. CPAC staff members are located both at the regional CPAC and at each VAMC in an effort to improve coordination and communication between the two entities.

²⁸⁴ Public Law 110-387, Section 406.

A.1.3 First Party

The following table depicts the financial health benefit co-payment obligations of Veterans whose income exceed VA income limits and those Veterans who choose not to complete the financial assessment during enrollment:²⁸⁵

Table A-2 VA Copays²⁸⁶

Priority Group & Inpatient/Outpatient²⁸⁷	Services	Copay Due
Priority Group 1	Same services are generally available to all enrolled Veterans	None
Priority Group 1	Prescriptions: 30-day or less supply of medication	None
Priority Group 2	Same services are generally available to all enrolled Veterans	None
Priority Group 2	Prescriptions: 30-day or less supply of medication	\$8 (Limited to \$960 annual cap)
Priority Group 3	Same services are generally available to all enrolled Veterans	None
Priority Group 3	Prescriptions: 30-day or less supply of medication	\$8 (Limited to \$960 annual cap)
Priority Group 4	Same services are generally available to all enrolled Veterans	None
Priority Group 4	Prescriptions: 30-day or less supply of medication	\$8 (Limited to \$960 annual cap)

²⁸⁵VA Health Benefit co-payments: <http://www.va.gov/HEALTHBENEFITS/cost/copays.asp>

²⁸⁶VA 2015 Co-payment Rates, http://www.va.gov/healthbenefits/resources/publications/IB10-430_copay_rates.pdf

²⁸⁷Note: There are two inpatient copay rates, the full rate and the reduced rate (20 percent of VA's inpatient copay rate). A letter accompanies the bill explaining the charges, along with VA contact information for questions. If the patient does not respond within 90 days, the bill enters a Biller's work list at the CPAC. The CPAC is responsible for reaching out to patients with outstanding debts, verifying eligibility and copay amounts, matching Third Party insurance payments to First Party copays, answering Veteran questions, setting up payments plans, processing Veteran refunds through VA Patient Account Resource System (VAPARS) system, and conducting follow-up duties to clear the debt. After 90 days, unpaid Veteran bills are sent to VA's Debt Management Center (DMC) for collection, and if collection efforts remain unsuccessful, bills are transferred to the Treasury Offset Program (TOP).

Assessment I (Business Processes)

Priority Group & Inpatient/Outpatient ²⁸⁷	Services	Copay Due
Priority Group 5	Same services are generally available to all enrolled Veterans	None
Priority Group 5	Prescriptions: 30-day or less supply of medication	\$8 (Limited to \$960 annual cap)
Priority Group 6	Same services are generally available to all enrolled Veterans	None
Priority Group 6	Prescriptions: 30-day or less supply of medication	\$8 (Limited to \$960 annual cap)
Priority Group 7 Inpatient	Copay for the first 90 days of care during a 365-day period	\$252
Priority Group 7 Inpatient	Copay for each additional 90 days of care during a 365-day period	\$126
Priority Group 7 Inpatient	Daily Charge	\$2/day
Priority Group 7 Outpatient	Prescriptions: 30-day or less supply for higher income Veterans	\$9 (No medication copay annual cap)
Priority Group 8 Inpatient	Copay for the first 90 days of care during a 365-day period	\$1,260
Priority Group 8 Inpatient	Copay for each additional 90 days of care during a 365-day period	\$630
Priority Group 8 Inpatient	Daily Charge	\$10/day
Priority Group 8 Outpatient	Prescriptions: 30-day or less supply for higher income Veterans	\$9 (No medication copay annual cap)
Outpatient	Primary Care	\$15
Outpatient	Specialty Care	\$50
Geriatric and Extended Care	Inpatient Copay	Up to \$97 per day (Community Living (Nursing home), Respite, Geriatric Evaluation)

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Priority Group & Inpatient/Outpatient²⁸⁷	Services	Copay Due
Geriatric and Extended Care	Outpatient Copay	\$15 per day (Adult Day Health Care, Respite, Geriatric Evaluation)
Geriatric and Extended Care	Domiciliary Copay	\$5/day
Long Term Care	Spousal Resource Protection Amount	\$119, 220

A.2 Non-VA Care

A.2.1 Technology to Enable Oversight of Claims Processing Performance

Decision support systems or BI tools allow organizations to analyze their data effectively. Data used in claims are significant drivers for analytics and informed decision-making. Decision support systems play a key role in, “data warehousing, security, standard and ad hoc analytics, care and disease management, fraud and abuse detection, other-party liability administration, and financial functions such as forecasting and reporting.”²⁸⁸ Leaders depend upon accurate and detailed data to make informed financial and clinical decisions. Lack of reliable and complete data impairs leaders’ abilities to analyze their health care delivery systems regarding appropriateness and quality of care, financial management, and all aspects of operations.

Leading health insurer practices involve, “[extracting] and [manipulating] key elements...to make virtually all data elements reportable so that [payer] analysts can include any number of factors in business and health care improvement needs.”²⁸⁹ For example, insurers routinely use reports to track trends and patterns in denied or pending claims, and then to identify potential root causes of those claims denials and pending claims. They also use reports to identify patterns in claims volume over time, so that they can deploy appropriate numbers of staff to work through anticipated claims backlog, staff provider services hotlines or conduct provider outreach.

VA’s Informatics team performs most of the decision support and BI analysis for VA for Non-VA Care claims. When VHA leadership needs reporting on clinical or financial metrics, the informatics team creates the reports primarily using data from paid claims processed through FBCS and VistA.

A.2.2 Overview of Care Authorities

Three main authorities provide VA the ability to purchase care for Veterans in the community. The following list describes these authorities.

²⁸⁸ Peter Kongstvedt “Essentials of Managed Care” Fifth Edition, 2007 Pg. 398

²⁸⁹ Ibid.

Assessment I (Business Processes)

- 38 U.S.C. 1703 – Authorized; 38 U.S.C. 1703, Authorized Care, allows for VA to contract with non-department facilities and provide care to Veterans with a service connected disability when VA is not capable of furnishing the care or services and geographical inaccessibility.²⁹⁰
- 38 U.S.C. 1728 – Unauthorized; 38 USC 1728, Unauthorized Care for a service Connected Disability, allows VA to reimburse for emergency care related to a service-connected condition.²⁹¹
- 38 U.S.C. 1725 – Millennium Bill (Mill Bill), 38 USC 1725, Millennium Bill, allows VA to reimburse a Veteran or the provider of emergency care for a non-service connected condition. The Veteran must not be covered by 38 USC 1703 (Contracts for Hospital Care and Medical Services in Non-Department Facilities) nor 38 USC 1728 (Reimbursement of Certain Medical Expenses). In order for the Veteran to be eligible for care under this authority, the Veteran must meet the following criteria:²⁹²
 - Veteran received health care services from VHA during the 24- month period preceding the emergency treatment
 - Veteran has no other form of health insurance coverage for the episode of care being claimed
 - VHA or other Federal facilities were not feasibly available at the time of the emergency
 - Care was rendered in a medical emergency of such a nature, that a prudent layperson would have reasonably expected a delay in medical treatment to be hazardous to life or health
 - Treatment was provided in a hospital emergency room department or a similar facility providing emergency care to the public
 - Veteran is financially liable to the provider for payment of the emergency treatment received
 - Veteran has no other contractual or legal recourse against a third party that would, in whole, extinguish the Veteran's liability, and the Veteran has exhausted all claims against a third party without success
 - Care beyond the medical emergency is for a continued medical emergency such that the Veteran could not safely discharge or transfer to a VHA facility (unless the Non-VA provider makes and documents reasonable attempts to transfer the Veteran).

²⁹⁰ 38 U.S. Code § 1703 - Contracts for hospital care and medical services in non-Department facilities - <https://www.law.cornell.edu/uscode/text/38/1703>

²⁹¹ 38 U.S. Code § 1728 - Reimbursement of certain medical expenses - <https://www.law.cornell.edu/uscode/text/38/1728>

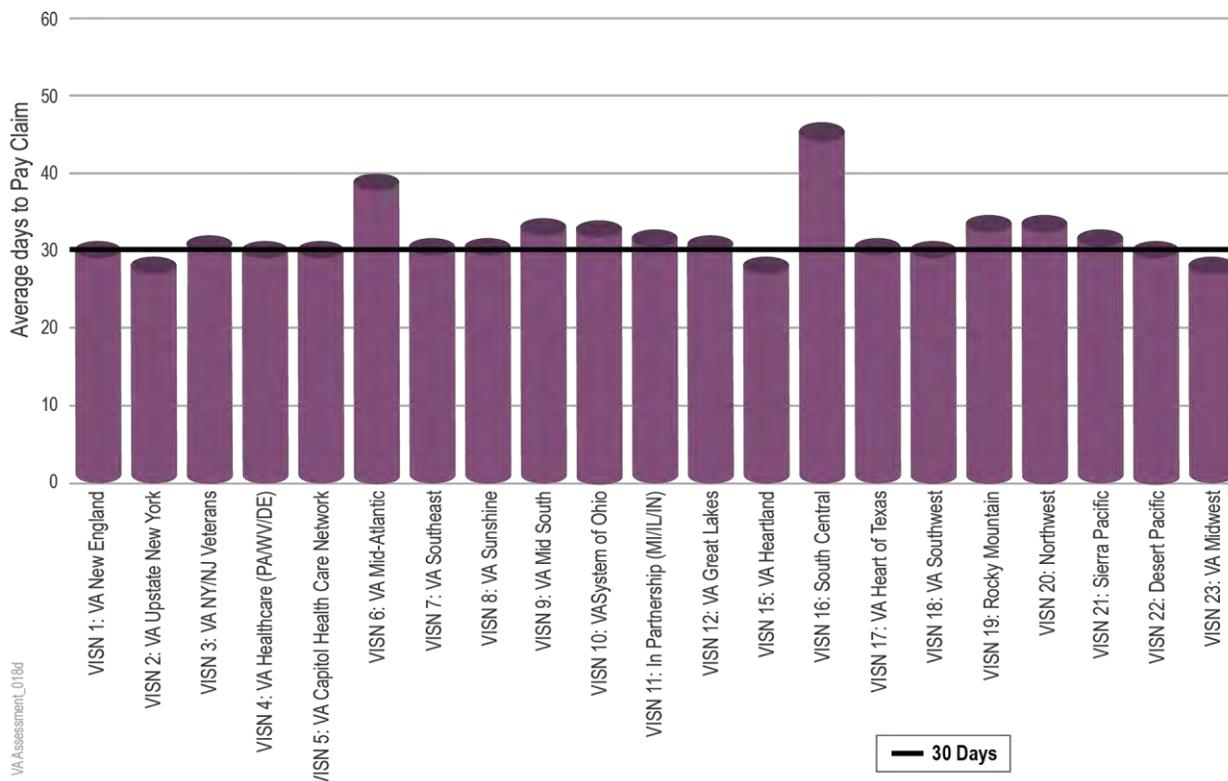
²⁹² 38 U.S. Code § 1725 - Reimbursement for emergency treatment - <https://www.law.cornell.edu/uscode/text/38/1725>

A.2.3 Timeliness by VISN

At the VISN level, Figure A- shows that a number of VISNs have average claims processing timeframes of 30 days or less, many slightly exceed the timeframe, and only two VISNs have processing times far exceeding the 30 day benchmark.

Figure A-1 Average Number of Days to Pay a Claim from Receipt Date for FY 2014²⁹³

Only 8 VISNs Paid Claims in 30 Days or Less, on Average



Source: Paid Data and Timeliness FY12-FY14 Data

To better understand VISN 16’s relatively high processing time, we interviewed Non-VA Care leadership within VISN 16. The VISN reported a technical issue with its FBCS server that caused a significant backlog and increased time to adjudicate claims in FY 2014. This issue has since been resolved.

Most of the VISNs, through sheer will and extensive manual labor, are meeting or close to meeting the timeliness standards, despite the volume of claims being processed, the associated complexities, and the technology challenges that exist.

²⁹³ Per Paid Data and Timeliness FY12-14 v2.xlsx prepared by CBO Department of Informatics; excludes Manila and VAMCs with less than 1000 claim lines

A.2.4 Detailed Authorized Care Process

- **Consult/Referral:** The Non-VA Care process begins when a VA provider makes a determination that the patient is in need of medical care VHA is unable to provide. Once the VA Provider determines the need for Non-VA resources, he or she creates a consult in Computerized Patient Record System (CPRS). A consult is the formal documentation in CPRS used to refer a Veteran for Non-VA Medical Care. The consult includes the requested services and justification for purchasing care from the community.
- **Authorization and Scheduling (Non-VA Care Coordination):** Once the VA Provider enters the consult, CPRS routes the claim to the Non-VA Care Coordination claims clerk. The administrative review ensures that the Veteran is eligible to receive Non-VA Medical Care and that VHA is unable to provide the requested treatment. Once the NVCC confirms the Veteran meets the eligibility requirements for Non-VA Care, he or she initiates a new authorization in FBCS. While CPRS automatically populates demographic information via the interface, the NVCC Claims clerk manually enters the services authorized into FBCS. Once FBCS has the authorization created, the claims clerk contacts the Veteran to identify his or her preferences for time for the appointment and Non-VA Provider. Non-VA Providers are health care professionals who prescribe medications, such as doctors, nurse practitioners, or physician’s assistants employed by private hospitals or facilities, such as hospitals. The NVCC claims clerk then reaches out to the Non-VA Provider to schedule the appointment. After confirmation of the appointment, the NVCC claims clerk sends notification to the Veteran. In addition to notifying the Veteran, the NVCC Claims clerk also sends notification to the Non-VA Provider. The letter confirms the specific medical services for which VHA will reimburse the Non-VA Provider.
- **Mode of Claims Submission:** When providers render services, they must bill payers for reimbursement. Providers can submit claims via paper or electronically. Paper standards include:
 - UB-04—this form is for institutional providers, such as hospitals. Both inpatient and outpatient claims are commonly billed on the UB-04.
 - CMS-1500—this form is for physicians and other individual providers. A doctor administering a physical in his office would generally use the CMS-1500 for billing.
 - ADA claim form—this form is used by dentist to submit claims.
- **Paper Claims - Scan/Verify:** For VHA and other payers, processing paper claims requires additional steps relative to processing electronic claims. VHA calls these steps Scan, Upload, and Verify. The “Scan” process transforms the information on the paper document into data for Fee Basis Claims System (FBCS). The “Upload” process brings the data into FBCS. During “Verify,” claims clerks manually ensure that the OCR process read the data correctly. These steps are similar for other private payers.
- **Electronic Claims Submission:** For electronic claims, the Scan, Upload and Verify steps are unnecessary because electronic claims data enters the system directly and without manual intervention. Thus, electronic claims enter the system more quickly and generally process more accurately, relative to paper claims.

Assessment I (Business Processes)

- Generally, the more a payer electronically automates claims processing, the cheaper and more reliably their systems operate.²⁹⁴ Most commercial and other government payers actively encourage their providers to submit all claims electronically. Providers submit electronic claims using a national standard format, the Electronic Data Interchange (EDI) format. These national EDI standards include:
 - 837I—this is the electronic format for institutional providers (replaces the UB-04)
 - 837P—this is the electronic format for physicians and other providers (replaces CMS-1500)
 - 837D—this is the electronic format for dental providers (replaces ADA form)
- The ANSI “chartered the ASC X12 to develop uniform standards for inter-industry electronic exchange of business transactions-electronic data interchange (EDI)”.²⁹⁵ This body created the 837 implementation guides referenced above. However, payers create 837 “companion guides” to assist providers with further instructions on billing electronic claims. For example, Medicare states that they publish companion guides to “clarify, supplement and further define specific data content requirements to be used in conjunction with, and not in place of, the ASC X12”²⁹⁶ implementation guides. Currently VHA does not have a companion guide to provide additional guidance on electronic claims submission.
- Processing claims electronically is less costly and more accurate²⁹⁷ than paper claims. Electronic claims are also processed faster²⁹⁸.
- Processing: The purpose of adjudication is to apply a series of rules that will ultimately determine if the claim should pay, deny or reject and to also determine the rate the claim should pay. Whenever providers render services, they expect reimbursement at mutually agreed upon rates. Providers expect the payment to be timely and accurate. However, the provider must satisfy a level of completeness and correctness when billing their claim for it to pay. Generally, the rules on billing completely and correctly are defined in the provider and billing manuals produced by the payer. If the provider bills

²⁹⁴ 2013 U.S. Healthcare Efficiency Index, CAQH, Electronic Administrative Transaction Adoption and Savings, Revised May 5, 2014 “We conclude that the healthcare industry could save billions by continuing the shift from manual to electronic transactions for the six processes [claims submissions, eligibility verification, prior authorization, claim status inquiry, claim payment and claim remittance advice/electronic payments] studied. We estimate that most of the potential savings from continued automation of routine processes would accrue to healthcare providers and facilities.”

²⁹⁵ <http://www.x12.org/about/faqs.cfm>

²⁹⁶ <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html>

²⁹⁷ 2013 U.S. Healthcare Efficiency Index, CAQH, Electronic Administrative Transaction Adoption and Savings, Revised May 5, 2014 “Today, individual providers, facilities, payers, and related business partners conduct more administrative transactions electronically than ever before, streamlining workflows for greater productivity, improving data accuracy, and reducing administrative costs.”

²⁹⁸ AHIP, Center for Policy and Research, Update: A Survey of Health Care Claims Receipt and Processing Times, 2013—93 percent of electronic claims are processed within two weeks versus 79 percent for paper claims

the claim incorrectly or without sufficient level of detail, the payer should reject or deny the claim with information on why the claim rejected or denied. If the member is covered and the service is in-plan, the provider can rebill the claim for reimbursement. The adjudication process helps bill claims correctly, and when they are not, the process denies or rejects the claim to the provider. The adjudication process also prices the claim. For VA, a denial means VHA policy does not cover the claim. Reasons for denial include the Veteran not being eligible or the provider rendering services without an authorization. When VHA denies a claim, the Veteran and provider receive notification that the service is not covered under policy and the provider should seek reimbursement from the Veteran. Conversely, a rejection means that there is a coding or administrative issue with the claim. For rejections, if the provider corrects the issue, they can resubmit the claim for VHA for reimbursement. Providers cannot seek reimbursement from the Veteran for rejections. VHA utilizes Fee Basis Claims System (FBCS), a Commercial-Off-The-Shelf (COTS) product, and Veterans Health Information Systems and Technology Architecture (VistA) to perform adjudication functions. FBCS adjudicates a majority of claims²⁹⁹, with the few exceptions processed in VistA or other tools. FBCS was created from an OCR tool that interfaced with a claims rules engine for VA. This means that FBCS did not start as an adjudication system optimized to adjudicate claims automatically. As a result, the operational processes are much more manual than those found in private sector systems.

A.2.4.1 Distribution

Once the claim is entered in FBCS and has undergone the “Verify” process, the claim enters the “Distribution and Processing” module. Within this module, claims clerks process the claim to validate a number of criteria, such as:

- Using Veteran eligibility files, determine the Veteran’s eligibility for coverage of the service(s) provided, and
- Using prior authorization information, determine whether the service required prior authorization and, if required, whether VHA issued the authorization. During “Distribution”, claims clerks manually associate the authorization to the claim.

A.2.4.2 Pricing

After the claims clerk associates the authorization to the claim, the clerk clicks the “Calculate” button, which sends the claim to pricing. This process takes up to two days. During this period, the claim processes through the Program Integrity Tool (PIT), as described in the next section. The claim returns with the Medicare price on the line. If the line’s submitted charge is less than the Medicare price, FBCS displays the line-allowed charge in yellow. When the allowed charge is yellow, the claims clerk must manually change the line price to the billed charge by selecting a

²⁹⁹ Claims not processed through FBCS include: Pharmacy, Dental, Adult day care, bowel and bladder, Home Health for contract nursing homes claims, newborn, and Dialysis. Dialysis claims processed in COTS product, not VistA. All other claims processed in VistA.

drop-down. For contracted claims, the clerk manually enters the correct rate by keying the rate into the claim line. For PC3 claims, the claims clerk selects the price by using the drop-down box and selecting the correct rate.

A.2.4.3 Editing

During processing, the system also applies various edits to the claim. Examples of the types of edits employed in automated adjudication might include:

- Member eligibility edits, such as determining whether the member is eligible for services,
- Provider edits, such as determining whether the provider is eligible to render services,
- Duplicate checking, to deny claims for which an exact duplicate claim has previously been paid,
- Clinical and Coding edits, such as determining whether the procedure and diagnosis are clinically appropriate together, determining if there is a procedure code gender conflict (e.g., a hysterectomy billed for a male) or detecting unallowable combinations of procedures, and
- Other edits, such as validating timely filing, enforcing date checks, and confirming that nationally standard codes are submitted.

At VA, a claims clerk manually works each edit that posts to the claim. This means that the claims clerk analyzes the edit, edit description and other claims information to determine if the edit should pay, deny or reject the claim or claim line.

A.2.4.4 Post Adjudication/Pre-payment Accuracy Mechanisms

Within the “Processing and Distribution” module, claims feed into technical tools and edit checks such as Claims Scrubber, Program Integrity Tool (PIT) and Quality Inspector Tool (QIT).

The Program Integrity Tool (PIT) is used to detect Fraud, Waste and Abuse (FWA) for Non-VA Care claims submitted for reimbursement and avoid improper payments. The PIT tool was created from a commercial fraud, abuse and waste tool used to monitor claims payment for commercial clients. As such, issues commonly identified during adjudication in commercial systems are also identified on VA’s claims. When clerks submit claims to calculate pricing, the claims also process through PIT, which applies predefined rules to the claim. Claims return from this process within two days for further processing by the clerk. The PIT tool performs additional checks related to the evaluating the reasonableness of diagnosis codes, procedure codes and other codes on the claim. PIT identifies issues such as determining whether the provider’s name exists on Medicare’s exclusionary list, finding duplicate claims, and identifying missing data on a claim line. Currently, all FBCS claims process through PIT.

The Quality Inspector Tool (QIT) reviews data extracted from medical and facility claims prior to payment for accurate claims processing. VHA created QIT based upon claims reports run at Minneapolis VAMC. VAMCs run QIT prior to submitting the batch for payment. The tool consists of automated inspections, which provide results on pass/fail basis. The report identifies the reason for each fail, such as incorrect payment methodology applied. When the tool identifies claims as “fails,” further review is required—the claim may not contain an accuracy issue. Once

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

QIT identifies a failure, staff investigates the claim using the claim ID number. If the claim complies with VHA policy, the fee clerk or supervisor will override the error.

The tool also tracks individual payment processing performance using trend charts and performance summaries by fiscal year. At current, using QIT is not mandatory. Our team visited a VAMC that choose not to run QIT as part of their processing. VA, however, is working towards integrating the QIT checks into PIT. From interviews with staff concerning the QIT tool, it seems VHA created the QIT tool to find errors that would normally not occur in a more automated system; when a centralized, highly-automated claims adjudication system is implemented, the QIT tool may no longer be needed. Additional analysis on the QIT tool is necessary when this transpires.

Based on the results of these tests, the claims clerk applies any necessary changes to the claim. If a reject/deny suggestion is in-line with VHA guidance, the claims clerk or supervisor can override the error.

A.2.4.5 Payment

The purpose of the payment process is to report which claims are paid and denied, report the rate of payment on the claims, report why claims are denied, and create a check for all “paid” claims.

For VA, once the claim has undergone processing, the claims clerk approves or denies line items on the claim for payment. The claims clerk acknowledges the line item approval by using the “Send to Payment” function that routes the claim to pricing, the next step in the process. In the event a line item or multiple line items on the claim do not meet the necessary requirements, the claims clerk denies or rejects the claim. The clerk uses the “Deny” function in the Distribution and Processing Module. After denial or rejection, the claims clerk documents the reason for denial in the message box and notifies the Non-VA provider.

The “Send to Payment” function in FBCS routes the claim to Central Fee System located in Austin, TX. Within Central Fee, the claims clerks perform additional edits and send the claim to FMS for payment. FMS calculates the interest for the claim, if applicable. The payment process sums paid claims, creates checks, and creates remittance advices to send to providers. Remittance Advices describe the reason for claims denials.

A.2.4.6 Return of Medical Documentation

After the date of the appointment passes, the authorization clerk contacts the Veteran to verify that the appointment took place as expected. If it did occur, the NVCC authorization clerk contacts the Non-VA Provider to obtain necessary medical documentation from the patient’s visit. Once the NVCC authorization clerks receive the documentation, he or she closes out the consult in CPRS.

A.2.5 Detailed Emergent Care Process

In emergent care, VA reimburses community providers for emergency treatment when the urgency of the situation does not allow for pre-approval. Section 2 describes the differences between Unauthorized and Mill Bill.

- Notification from Emergency Department (ED)/Receipt of Claim
- When a Veteran presents to a Non-VA Emergency Department (ED), the Non-VA hospital notifies the local VAMC. The Non-VA hospital alerts VHA in one of two ways:
 - Receipt of a phone call when the Veteran is admitted to the ED
 - Receipt of bill from the ED

Once the Non-VA hospital notifies VHA of the admitted Veteran, a transfer coordinator will monitor the situation. If the care is inpatient, the transfer coordinator documents the Veteran admitted to the hospital. If service connectedness is established and the hospital notifies VHA within 72 hours, the transfer coordinator can immediately create a tentative authorization. The tentative authorization allows the Non-VA provider to stabilize the Veteran to the point of discharge or transfer to the nearest VAMC. VHA categorizes the tentative authorization as “review for payment.”

The other means of notification is the receipt of a claim. In some instances, VHA is not aware of the Veteran’s admission to a Non-VA hospital until they receive the claim and additional medical documentation. In this case, the claims clerk scans the claim and supporting documentation into FBCS to perform an administrative review of the medical records. In this case, when the clinician determines the visit meets medical necessity standards (discussed in Section 4.2), the NVCC clerk creates an authorization. VHA uses the authorization to pay all claims related to the emergency visit.

A.2.5.1 Processing and Payment

The processing and payment on Unauthorized and Mill Bill claims follows closely to that of Authorized claims as discussed in Section 3.3, but with a few exceptions.

A.2.5.2 Eligibility and Coordination of Benefits

The claims clerk reviews the Veterans service connectedness rating and determines if the Veteran is eligible for Non-VA Care. In addition, they check the Veteran profile in VistA for evidence of a third-party insurance. The service connectedness and third-party insurance are critical determinations to ensure the correct payment authority is used. For example, as mentioned above in Section 2.3 Millennium Bill, if the Veteran is non-service connected and does not have other insurance, the care may be approved under 38 USC 1725. If the Veteran is service-connected, VHA can only approve the care can under 38 USC 1728.

A.2.5.3 Clinical Review

A clinician must review unauthorized claims received at the VAMC to determine medical necessity. A visit to the ED, in and of itself, does not justify medical necessity. A designated VHA

Fee clinician performs all clinical reviews for unauthorized claims. The Clinical Reviewer reviews the Non-VA claim and provider notes, in addition to considering the judgment of a prudent layperson (one who possesses an average knowledge of health and medicine would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health). The clinical reviewer ensures the encounter was emergent in nature and the VAMC was not feasibly available at the time.

A.2.6 Detailed Information on the Choice Program

A.2.6.1 Process Overview/Consolidation of Payment

If the Veteran meets one of the eligibility criteria above, VHA places him or her on the Veterans Choice List (VCL). The VCL serves as a way of verifying eligibility and guaranteeing payment for the Non-VA Provider. Before seeking care from a Non-VA Provider, the Veteran should call VHA to ensure that he or she is eligible for the Choice Program. VHA authorizes care upon eligibility confirmation and schedules an appointment with a Non-VA Provider. VHA has expanded contracts with the PC3 vendors described above to help administer Choice program. While use of the PC3 vendor's networks are preferred the Veteran can select their own provider outside of PC3, however, VHA must approve them in advance. If PC3 administers the care, HealthNet or TriWest is responsible for creating the authorization and scheduling the care.

The PC3 vendor or the Non-VA Provider (if PC3 is not used) submits the claim to VHA upon services rendered. The claims processing and payment processes are consistent with those of traditional Non-VA Care as described in Section 3.4. VHA routes all Choice claims to the Health Administration Center (HAC) in Denver, CO, but the claims are processed virtually using the St. Louis VAMC FBCS server.

- 30-day eligibility: provides eligibility for the Veteran if she/he has attempted to schedule an appointment with VA, and VHA is unable to schedule the appointment within 30 days of his or her preferred date.³⁰⁰
- 40-mile eligibility: provides eligibility for Veterans residing more than 40 miles from a VHA medical facility that is closest to their residence. This includes any VHA facility even if that facility is not capable of providing the required services.³⁰¹

A.2.7 Detailed Information on PC3

VHA contracted with HealthNet and TriWest to provide Veterans with access to care through a network of community-based providers. PC3 vendors serve as administrators of the contract and act as intermediaries between VHA and their network providers. PC3 vendors manage networks of providers, coordinate care for the Veteran, and reimbursement network providers for care. PC3 vendors submit claims to VHA in accordance with their stated contracts. VHA instituted PC3 to improve Non-VA Care process. Examples include:

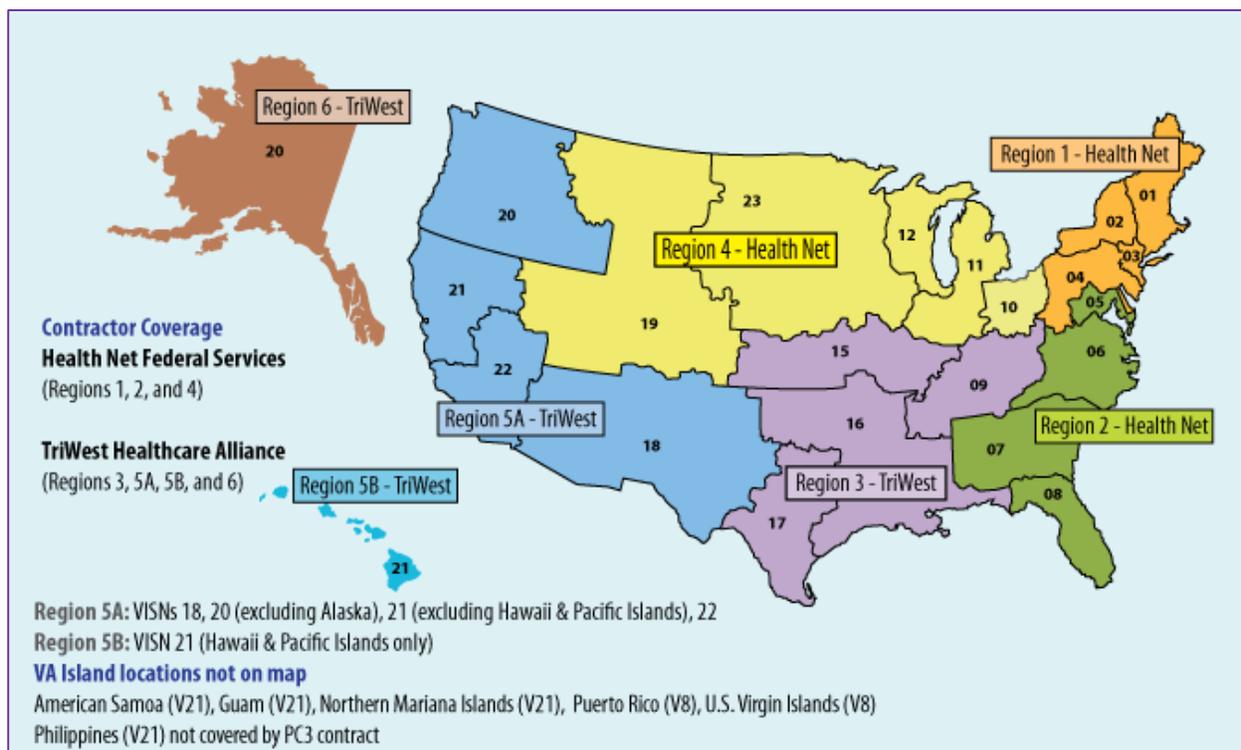
³⁰⁰ Section 101 of the Veterans Choice Act (§ 17.1510(b)(1))

³⁰¹ Ibid.

Assessment I (Business Processes)

- Ensure quality as providers and facilities meet quality standards
- Provide efficiency as providers help the VA Medical Centers (VAMC) manage high volumes of one type of care. Contractors set appointments and authorizations do not require additional contracting review
- Provide convenient method for Veterans to be seen quickly and within required commute times
- Decrease improper payments as payment rates are defined by the contract and contractors perform an additional level of review to ensure services performed match the authorization and were billed correctly to VA
- Support care coordination by providing medical documentation back to the VAMC in a timely manner
- Standardize processes by providing national contract administration and oversight from the CBO Purchased Care, and integrating into Non-VA Care Coordination processes

Figure A-2. Vendors Serving in Each PC3 Geographic Region



Source: VHA map of vendors serving PC3 geographic regions.

The process starts when a Veteran requires care and the Veteran is covered under the PC3 eligibility standards. VHA creates an authorization for the Veteran and submits it to HealthNet or TriWest based on the Veteran's region. Upon authorization, the vendor is responsible for scheduling an appointment for the Veteran. The PC3 contractor must contact the Veteran regarding the scheduled appointment and provide appropriate information about the appointment. According to PC3 contracts, the appointment must be scheduled within five days

of receipt of authorization and take place within 30 calendar days of scheduling the appointment.³⁰²

Additionally, the PC3 provider rendering the care must submit supporting documentation to VHA upon completion of the appointment. According to the HealthNet contract, VHA requires that, “Medical documentation recoding of authorized episode of outpatient care shall be submitted to VHA within 14 calendar days after completion of the initial appointment.”³⁰³

The following subsections briefly describe other PC3 vendor responsibilities, as well as the related business processes, related to billing and payment.

A.2.7.1 Processing and Payment

PC3 vendors reimburse providers within their network. PC3 vendors contract directly with their network providers or otherwise coordinate with providers of medical services. PC3 vendors also are responsible for coordinating care delivering and returning medical documentation. Once the PC3 vendor reimburses the providers and receives the medical documentation, the PC3 vendor submits the claims to VHA for payment through FBCS. VHA processes PC3 claims similarly to all other claims.

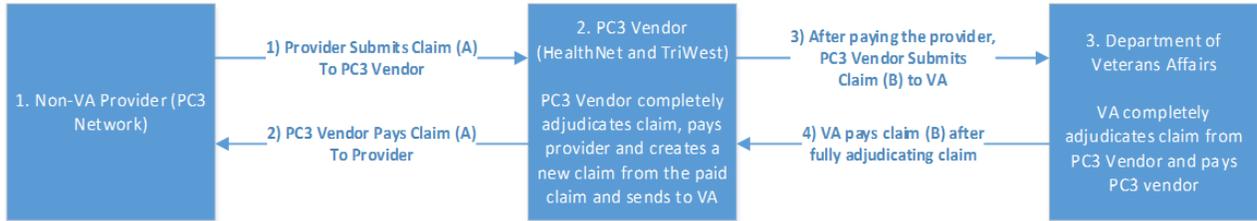
While the PC3 vendors serve a function similar to a Third Party Administrator (TPA), some processes differ from traditional payer/TPA relationships. Typically, payers employ TPAs to support the operational functions necessary for adjudication and paying claims, such as processing and paying claims. The payer, in this scenario, outsources this function; the TPA will perform the claims operations functions, in this case, instead of the payer performing this function directly. Medicare, for example, contracts with 16 Medicare Administrative Contractors (MACs) to process their Part A, Part B, Durable Medical Equipment (DME), home health and hospice claims³⁰⁴. For Medicare, the claims are adjudicated by the MAC instead of by Medicare directly. For VA, the claims adjudication and payment functions occur at both VHA and the PC3 vendor.

³⁰² Department of Veterans Affairs (2014), Patient Centered Community Care, *Contracts Provide Primary Care Access*

³⁰³ HealthNet Contract

³⁰⁴ <http://www.medicarenewsgroup.com/news/medicare-faqs/individual-faq?faqId=c8e2f9da-cec3-45ed-afa0-adb6ffbf68a7> Medicare Administrative Contractors, or MACs, are private organizations that carry out the administrative responsibilities of Traditional Medicare (Parts A and B). They also handle durable medical equipment, home health and hospice claims. Currently, there are 12 contracts for Parts A and B, which the Centers for Medicare & Medicaid Services (CMS) is consolidating down to just 10 contracts over the coming years. Four separate contracts have been rewarded for durable medical equipment claims processing.

Figure A-3. PC3 Reimbursement Process



This page intentionally left blank.

Appendix B Interviews and Site Visits

Methodology Used to Determine Site Visits and Conduct Interviews

Table B10-1. Site Visit Locations and Functions Interviewed

VISN	Station Name	City	State	Functions Interviewed
4	Corporal Michael J. Crescenz VA Medical Center	Philadelphia	PA	Fee Supervisor, Compliance, VA Provider, NVCC Clinical Review Nurse, NVCC Management, Revenue Management, and Leadership
6	Mid-Atlantic CPAC	Asheville	NC	Facility Revenue, Insurance Verification, Revenue Utilization Review, Internal Controls, Billing, Accounts Management, Denials Management Veterans Services, Payer Relations, and Leadership
8	Florida CPAC	Orlando	FL	Facility Revenue, Insurance Verification, Revenue Utilization Review, Internal Controls, Billing, Accounts Management, Denials Management Veterans Services, Payer Relations, Cash Management, and Leadership
8	Bruce W. Carter VA Medical Center	Miami	FL	Compliance, Patient Intake/Registration, Patient Administration Services, CDI, Facility Revenue, and Leadership
11	Ann Arbor VA Medical Center	Ann Arbor	MI	Compliance, Health Administration Services, Patient Intake/Registration, Medical records, Revenue Utilization Review, Facility Revenue, and Leadership

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

VISN	Station Name	City	State	Functions Interviewed
12	William S. Middleton Memorial Veterans Medical Center	Middleton	WI	Facility Revenue, Insurance Verification, Revenue Utilization Review, Internal Controls, Billing, Accounts Management, Denials Management Veterans Services, Payer Relations, Cash Management, and Leadership
12	Edward Hines Jr VA Medical Center	Hines	IL	Compliance, Patient Intake/Registration, Utilization Review, Medical Records/HIMS, Facility Revenue, and Leadership
16	Gulf Coast VA Medical Center	Biloxi	MS	Compliance, Revenue Utilization Review, Medical Administration Services, Patient Intake/Registration, Medical Records, Coding, Facility Revenue, and Leadership
17	Audie L. Murphy VA Medical Center	San Antonio	TX	Fee Supervisor, Compliance, VA Provider, Clinical Review Nurse, Medical Center Director, Deputy Chief of Staff, and Leadership
19	Chief Business Office-Purchased Care	Denver	CO	Program Administration, Program Oversight and Informatics, Purchase Care Operations, Business Systems Management, Purchased Care Resource Management, Non-VA Care Claims Audit Execution, and Leadership
19	George E. Wahlen VA Medical Center	Salt Lake City	UT	Compliance, VA Provider, Clinical Reviewer, NVCC Manager, Supervisory Program Specialist, FQAM, and Leadership

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

VISN	Station Name	City	State	Functions Interviewed
21	San Francisco VA Medical Center	San Francisco	CA	Patient Revenue Services, Fee Supervisor, Compliance, VA Provider, FQAM, NVCC Manager, and Leadership

The views, opinions, and/or findings contained in this report are those of Grant Thornton should not be construed as an official government position, policy, or decision.

This page intentionally left blank.

Appendix C Data Requests

C.1 Summary of Data Requests

This outlines the primary and secondary data requests submitted to VA by the VA Care and Non-VA Care teams.³⁰⁵ The following tables summarize the numbers of data requests needed, received, and retracted, as well as an overview on the numbers of documents collected to conduct this assessment.³⁰⁶

Table C-1. Team I Joint Data Requests with Other Teams

Team I Joint Requests with Other Teams

Total Number of Data Requests	55
# Data Meets the Need	54
# Data Submission Pending	1

% Data Meets Need	% Retracted
98.18%	0.00%

Table C-2. Team I Solo Data Requests

Team I Solo Data Requests

Total Number of Data Requests	86
# Data Meets the Need	77
# Request Withdrawn	9
# RR = Partial Fulfillment	5
# RR = Fulfilled as part of different data request	1
# RR = Duplicate Request	1
# RR = No longer needed	1
# RR = VA data not available	1

% Data Meets Need	% Withdrawn
89.53%	10.47%

³⁰⁵Note: Not all requested data was received.

³⁰⁶Note: Retracted or withdrawn data requests occurred when data needs were fulfilled by another data request.

Table C-3. Team I Documents Collected

Team I Documents Collected

Total Number of Documents Collected	690
In the Shared Document Repository	645
Document tagged only to Team I	193
Documents tagged to, including Team I	452
In the Private Team I Area	45

C.2 VHA Revenue Data Requests Detail

C.2.1 Primary Data Requests

- 1. Revenue Cycle Key Performance Indicators Reporting**
 - a. Monthly CPAC dashboard reports for last 12 months and reports used to monitor progress, productivity, and/or performance for Patient Intake and CPAC functions.
- 2. Accounts Receivable Aged Trial Balance Summary (ATB)**
 - a. ATB Summary: Totals for accounts receivable balances. Report should separate In house, Unbilled, and Billed AR. Billed AR should be aged in 30-day increments, and including the number of accounts and dollar values by financial class and aging category (date of report should be as of the most recent month end).
- 3. Summary Cash Collection Report**
 - a. Third party cash collections in total and by payer/financial class for each month over the past 12 months.
- 4. Revenue by Payer Report**
 - a. Revenue (gross and net charges) in total and by payer/financial class for the past 12 months.
- 5. Denials**
 - a. Reports for initial denials received across the CPACs for each month over the past 12 months.
 - b. Aggregate reports for denial write-offs for each month for the past 12 months, including standard denial adjustment codes and rejection category mapping. Include data for write-off of third-party billable amounts for last 12 months.
- 6. Patient Intake Summary Volume**
 - a. Summary volume data for the past 12 months for each VAMC for Patient Intake functions provided in percentage of patient totals that are scheduled in advance by VAMC for the last 12 months.
 - b. Percentage of patients where pre-registration and insurance verification is currently completed By VAMC for last 12 months.

C.2.2 Secondary Data Requests

1. Financials

- a. VHA Financial Statements for the last two fiscal years (FY).

2. Organization Charts

- a. Current organization charts including FTE's for Patient Intake functions (Admitting/Registration/Insurance Capture).
- b. Current organization charts including FTE's for Patient Financial Services/Consolidated Patient Account Center (CPAC).

3. Projects/Future Strategic Plans

- a. List of all major Patient Intake and Patient Financial Services projects (operational and technology) currently underway or in development.
- b. Copies of proposed or tentatively accepted future strategic plans across the revenue cycle function.

4. Revenue Cycle Policies and Procedures

- a. Electronic copies of insurance capture/verification and third-party collection policies and procedures.

5. Patient Intake Services, Patient Financial Services and Collection Agency/Vendor Reports

- a. List of existing vendors currently assisting Patient Intake Services and Patient Financial Services, including costs and performance reports. Include eligibility services, billing and follow-up outsourcing, contract payment compliance, etc.
- b. Most recent monthly performance reports from collection agencies and other outside vendors, which perform services as a part of the verification and third-party collection process.

6. Information Systems

Provide name(s) of the following information systems that are currently used at the organization to facilitate insurance verification and third-party collection efforts:

- a. Patient accounting/accounts receivable
- b. Insurance verification
- c. Denial management
- d. Patient management system for admissions/registration
- e. Remittance posting
- f. Scheduling
- g. Pre-billing edit and electronic billing
- h. Account follow-up

7. Summary Adjustments Report

- a. Monthly summary level adjustment reports in total and by major payer for the past 12 months.

8. DNFB & Bill Hold/Edits Reports

- a. 6 Months prior and most recent month-end Unbilled / Discharged Not Final Billed (DNFB) reports with bill hold reason by CPAC.
- b. Bill hold/bill edit reports, summarized by number and dollar by bill edit or reason from the Patient Accounting system for most recent month end.

- c. Bill hold/bill edit reports, summarized by number and dollar by bill edit or reason from any stand-alone (or bolt-on) bill editing systems utilized for most recent month end.
- d. Standard bill hold length for both inpatient and outpatient accounts.

9. Patient Financial Services Productivity

- a. Productivity data for the past 12 months: productivity standards and performance for the third-party collections area.
- b. Any reporting of errors, rejections, and denials detected per month related to patient financial services and Patient Intake errors.

10. Patient Intake Services

- a. Policies and procedures around the functions considered part of and reportable to Patient Intake (i.e., scheduling, pre-registration, insurance verification, onsite registration, financial counseling, cashier, information desk, etc.).

11. Patient Intake Productivity

- a. Insurance verification productivity data for the past 12 months.
- b. Any reporting of errors, rejections, and denials detected per month related to insurance verification errors.

C.3 Non-VA Care Data Requests Detail

C.3.1 Primary Data Requests

1. Non-VA Policies and Procedures

Provide Policies, Procedures and Guidance for Authorization, Processing, and Payment of Non-VA Care claims, to include:

- a. Deadlines for filing claims and appealing claims adjudication decisions.
- b. Reimbursement methodologies allowed (such as Diagnosis Related Groups (DRG), Resource-based relative value scale (RBRVS), Ambulatory Payment Classifications (APC), and Ambulatory Patient Groups (APG)).
- c. Veterans Health Administration (VHA) policies and procedures for defining eligibility to be a Non-VA health care provider.
- d. Rules, edits, policies, procedures, for Veterans Health Administration (VHA) as a secondary or primary payer on Coordination of Benefits (COB), Third Party Liability (TPL), Workers Compensation (WC), etc.
- e. Rules/systems for avoiding duplicate claim payments.

2. Related Process Documentation

- a. Flow chart detailing claims payment process including logging of claims, verification of eligibility, authorization, review process, claims edits, payment authorization, and payment date related to Non-VA Care payments.
- b. Data required for Fee Basis Claims System (FBCS) by each Department of Veterans Affairs Medical Center (VAMC) to process a claim (i.e., Veteran ID, provider ID, service, procedure code, revenue code, diagnosis, date of service (DOS), etc.). This request is for a listing of the data elements, not the actual data. This information can include 837 Companion Guide or Billing Manual instructions.

Assessment I (Business Processes)

- c. Documentation on requirements imposed on providers when submitting claims such as, filing deadlines, documentation, medical record information required, and authorization and pre-certification requirements (including any authorization decision turnaround time requirements for Veterans Health Administration (VHA)). If this varies across VA, include how this varies.
- d. Documentation on electronic/manual processes used by the Veterans Health Administration (VHA) to monitor payment compliance with regulatory/legal requirements. Also, provide information on the role of Program Integrity Tool in Fraud Waste and Abuse (FWA) and compliance checks.
- e. Documentation/electronic system for tracking high utilizers of Non-VA Care.

3. Non-VA Key Performance Indicators Reporting

- a. Management reports on claims payments, timeliness and accuracy by the Department of Veterans Affairs Medical Center (VAMC) for (along with the data sources for the reports):
 - Last 12 months on a monthly basis
 - Last three years on a yearly basis

4. Payment Accuracy and Timeliness

- a. Reports showing claims expense reductions and recoveries on Coordination of Benefits (COB), Third Party Liability (TPL), Workers Compensation (WC), etc. by the Department of Veterans Affairs Medical Center (VAMC) for the last 12 months as a percentage of billed charges and paid amounts.
- b. Any data (e.g., documented processes to determine accuracy, amount of inaccurate payments, internal or external audit information) the Veterans Health Administration (VHA) has related to accuracy of payment to vendors (by the Department of Veterans Affairs Medical Center (VAMC) and claim type), including rates of inaccurate payments based upon paper vs. electronic claims for these timeframes:
 - Last 12 months on a monthly basis
 - Last three years on a yearly basis
- c. Reports, by claim type, for the last 3 fiscal years (reported annually) on claims being submitted electronically and manually.
- d. Average length of time between date of receipt of claim and date of payment with as granular breakout as possible (e.g., by the Department of Veterans Affairs Medical Center (VAMC), claim type, and electronic versus paper claim) for the last 3 fiscal years (reported annually).

5. Information Systems

- a. Descriptions of all systems used in the adjudication of Non-VA claims (e.g., which claims adjudication system is each Department of Veterans Affairs Medical Center (VAMC) using, what COTS products are used during processing (such as McKesson/Bloodhound/iHealth for National Correct Coding Initiative (NCCI) edits or 3M for Diagnostic Related Groups (DRG) assignment).

6. Interest Penalties

- a. Number of claims and amount of billed charges, paid amounts and penalties paid to vendors with as granular of breakout as possible (e.g., by the Department of

Veterans Affairs Medical Center (VAMC) and claim type, such as inpatient, outpatient, physician,) for the last 3 fiscal years on an annual basis.

- b. Amounts of penalties paid by the Department of Veterans Affairs Medical Center (VAMC) showing penalties paid for claims submitted electronically vs paper with a breakout of billed amounts, reimbursed amounts, penalties, and raw claim counts with counts of claims with penalties.

7. Denials

- a. Summary level reports of percent of submitted claims paid and percent denied by VAMC (by claim type if possible) for the last 3 fiscal years (monthly or annual reports fine). Categorize denials by reason (service not prior authorized, TPL not present on claim, Veteran ID not on file, provider not on file, service not covered, duplicate check, utilization review issue, etc.) and include the allowed amounts denied by reason code.

8. Claims Processing Productivity

Management reports related to claims processing (e.g., edit descriptions for denials in adjudication system) for the last 3 fiscal years on an annual basis by the Department of Veterans Affairs Medical Center (VAMC):

- a. Percent of clean claims, total charges and amounts paid on those claims from Non-VA provider paid within 2 weeks of date of service/discharge
- b. Percent of clean claims, total charges and amounts paid on those claims from Non-VA provider paid within 30 days of date of service/discharge
- c. Percent of clean claims, total charges and amounts paid on those claims from Non-VA provider paid after 365 days of date of service/discharge
- d. Percent of clean claims suspended during first pass
- e. Percent of clean claims adjudicated within 5, 10, 15, 20, 25, 30, 60, 90, 120, 150, 180 days
- f. Percent of clean claims adjudicated automatically³⁰⁷
- g. Percent of claims where allowed amount equals the contracted amount

C.3.2 Secondary Data Requests

1. Organization Charts

Organization charts including Full-Time Equivalent (FTE's) for fee departments processing claims:

- a. Number of Staff scanning/entering claims
- b. Number of staff correcting/adjusting claims
- c. Staff providing Veteran and provider support

2. Policies, Procedures, and Related Documentation

³⁰⁷Note: *Clean claim* means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a payer's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Assessment I (Business Processes)

- a. Any policy and procedures related to creating agreements between the Veterans Health Administration and Non-VA health care providers for the provision of Non-VA health care services and sample copies of regional or national agreements of this nature. This may include:
 - Department of Veterans Affairs (VA) – national
 - Veterans Integrated Service Network (VISN)
 - Department of Veterans Affairs Medical Center(VAMC)-level
- b. Any rules regarding credentialing of Non-VA providers.

3. Information Systems

- a. Information regarding the electronic sharing of information with Non-VA providers.

4. Payment Accuracy and Timeliness

- a. Scrubbed example of typical invoices for each claim form and any non-standard claim information submitted (such as an invoice).
- b. Internal audit results of Non-VA Care for the past 3 fiscal years (e.g., Improper Payments Elimination and Recovery Act (IPERA), Management Quality Assurance Service (MQAS), Compliance and Business Integrity (CBI), External Auditor, etc.) for the last 12 months. Include any monthly reports for the last 3 years and any yearly reports.

5. Care Authorization

- a. Data on average, median and percentiles for logging a request for authorization and the decision date on the request for authorization by the Department of Veterans Affairs Medical Center(VAMC), claim type and number of authorization requests approved versus denied for the last 3 fiscal years on an annual basis for Inpatient Care.

6. Service Level Agreements (SLAs)

- a. Contractors, if any, utilized for functions related to vendor claim processing (e.g., discovery of TPL data, prior approval of services, etc.). If using contractors, provide copies of the Service Level Agreements (SLA).
- b. Patient Centered Community Care (PC3) Vendor Management information:
 - Patient Centered Community Care (PC3) vendor management (i.e., TriWest and HealthNet), key Service Level Agreements (SLAs) related to claims processing and payment with VA.
 - Other contracts (Choice or local contracts) key Service level agreements (SLAs) related to claims processing and payment.

7. Projects/Current Improvement Efforts

- a. Information related to the Non-VA Care Way Forward initiatives that affect claims processing and payment.
- b. Patient Centered Community Care (PC3) Vendor Management information:
 - Anticipated changes to processes and procedures related to Patient Centered Community Care (PC3) vendor management (i.e., TriWest and HealthNet) related to claims processing and payment with VA.
 - Oversight or performance reports (e.g., for claims processing, provider network exit interview findings, audits of vendors).
 - Other documentation communicating billing requirements to network providers (e.g., provider manuals, provider contracts, etc.).

- c. Information regarding any system enhancements and the manner in which they are anticipated to affect claims processing and payment.
- d. New policies around the role of CO (Contracting Officer) and Contracting Officer's Technical Representative (COTRs) in administering provider contracts for Non VA Care.

8. Interest Penalties

- a. Amounts of penalties paid by the Department of Veterans Affairs Medical Center (VAMC) showing penalties paid for claims submitted electronically vs paper with a breakout of billed amounts, reimbursed amounts, penalties, and raw claim counts with counts of claims with penalties.

Appendix D Standards and Benchmarks

D.1 VA Care: Private-Sector Benchmarks and Related VA Standards

Table D-1. VA Care Benchmarks and Related Standards

Process Area	Private Sector Benchmark	VA Measure	Differences
Insurance Identification	Overall advance insurance verification rate of scheduled patients: ≥ 98 percent (Source: HFMA).	Insurance Capture Buffer Exception Rate ≤ 10 percent.	VHA does not track insurance verification rate of scheduled patients; however, VA considers ICB exceptions missed identification opportunities.

Assessment I (Business Processes)

Process Area	Private Sector Benchmark	VA Measure	Differences
Clinical Documentation	No commercial benchmark available to cite, however, leading commercial practices are to hold clinicians accountable to finalize and submit documentation within 24-48 hours.	VA Clinicians have 7 days to submit their clinical documentation for encounter coding (per interview findings).	VHA report on date of discharge to date of transmission to coding inflates the clinical documentation lag time due to multiple reasons. As such, obtained outpatient billable latency percentage.

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Process Area	Private Sector Benchmark	VA Measure	Differences
Coding/Clinical Documentation Quality	No commercial benchmark or leading commercial practices are used to benchmark coding quality and turn-around time.	Denial Inflow Summary displays all denials broken down by Minor Denial Reason Code. Coding quality will be measured by taking Wrong Procedure Code denials as a percent of Total Denials to show the total number of denials that resulted from the wrong procedure code.	N/A
Health Information Management	Inpatient charts coded per coder/per day: 23-26 (Source: HFMA). Outpatient charts coded per coder/per day: 150-230 (Source: HFMA).	Commenting on VA benchmarks for IP turnaround time (7 days), OP turnaround time (14 days), and coding backlog. (Source: HIMS).	Productivity per coder is not available.
Gross Days Revenue Outstanding	HFMA does not publish a gross days in AR metric rather they state a net days in AR metric (55 days).	GDRO Detail Report: (AR Total \$ Monthly/ Average Daily Billings for the Previous 3 Months) VA FY14 Target: 43 days. (Source: Power+).	VHA does not track contractual adjustments, bad debt adjustments or the resulting net revenue. VA only tracks gross revenue.
Cash Collections	Cash Collection percent: $\frac{\text{Total Cash Collected (\$)}}{\text{Average Monthly Net (\$) Revenue}} = \text{Cash Collections as percent of Adjusted Net Patient Services Revenue}$.	Power+ Data - FMS Collections (Total Funds) Report calculates expected and actuals for FMS collections. (Source Power+). Total Cash Collection as a percent of Billed Gross Revenue each month.	Standard will have to be reported as a collections as a percent of gross revenue. VA does not track net revenue like the HFMA standard.

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

D.2 Non-VA Care: Private-Sector Benchmarks and Related VA Standards

Table D-2. Non-VA Care: Benchmarks and Related Standards

Process Area	Private Sector Benchmark	VA Measure	Differences
Accuracy	≥ 97 percent of claims processed and paid accurately.	Non-VA Care accuracy standard is 98.5 percent.	VHA does not review denied or rejected claims as part of their accuracy review.
Payment to Vendors	96 percent of clean claims are processed within 30 days.	90 percent of ALL claims to be processed within 30 days.	VHA does not track timeliness for “clean” claims. ³⁰⁸
Interest Payment	0.8 percent of claims included penalties or interest due to late payment.	.03 percent of the claims included penalties or interest due to late payments.	A review of VHA’s allocation of interest to claims is being conducted to assess whether interest was applied accordingly.
Mode of Claims Submissions	79 percent of all claims automatically adjudicated.	0 percent of the claims are automatically adjudicated.	Commercial systems created for high rates of auto-adjudication. FBCS created from OCR tool.

³⁰⁸Note: VHA changed timeliness standards for authorized (30 days) and unauthorized (45) claims. However, VHA does not officially designate claims as 'clean or unclean' by using edits. While a change was recently made, VHA's standard is still not comparable to industry standards.

Assessment I (Business Processes)

Process Area	Private Sector Benchmark	VA Measure	Differences
Payment	≥96 percent of payments are within 30 days.	90 percent of ALL claims to be processed within 30 days.	In 2014, only 66.9 percent of the claims were processed within 30 days.
Payment to Vendors	98.5 percent of claim lines paid.	~55 percent of claims paid.	Benchmark for claim lines and VHA measure is claims.

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

Appendix E References

- Advisory Board Company. (2014). Rethinking Clinical Documentation Improvement. Retrieved from <http://www.advisory.com/research/financial-leadership-council/white-papers/2014/rethinking-clinical-documentation-improvement>
- America's Health Insurance Plans (AHIP) Center for Policy and Research. (2013). Survey of Health Care Claims Receipt and Processing Times.
- CAQH. (2014). U.S. Healthcare Efficiency Index, CAQH, Electronic Administrative Transaction Adoption and Savings.
- Department of Veterans Affairs. (2009). Performance and Accountability Report. Retrieved from <http://www.va.gov/budget/report/>
- Department of Veterans Affairs Audit and Internal Controls. (2014). Non-VA Care Proper Payment Audit Report.
- Department of Veterans Affairs Chief Business Office. (2015). CBO Revenue Cycle Performance Metrics Panel for Fiscal Year 2015.
- Department of Veterans Affairs Chief Business Office. (2015). Patient Centered Community Care Authorization Audit.
- Department of Veterans Affairs Chief Business Office. (2014). Patient Centered Community Care Review of PC3 for Return of Medical Documentation.
- Department of Veterans Affairs Chief Business Office. (2014). The Way Forward (2014-2016) Revenue Operations Strategic Plans.
- Department of Veteran Affairs Chief Business Office. Purchase Care for Non-VA Medical Care Program. Retrieved from <http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/index.asp#PC3>
- Department of Veterans Affairs Office of Inspector General. (2015). Alleged Insufficient Staffing and Consult Management Issues, Carl Vinson VA Medical Center, Dublin, Georgia. (Report No. 14-04702-60). Retrieved from <http://www.va.gov/oig/pubs/vaoig-14-04702-60.pdf>
- Department of Veterans Affairs Office of Inspector General. (2015). Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings. Report No. 14-02916-336. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-14-02916-336.pdf>
- Department of Veterans Affairs Office of Inspector General. (2013). Review of South Texas Veterans Health Care System's Management of Fee Care Funds. (Report No. 11-04359-80). Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-04359-80.pdf>
- Department of Veterans Affairs Office of Inspector General. (2012). Audit of Non-VA Inpatient Fee Care Program. Report No. 09-03408-227 Retrieved from <http://www.va.gov/oig/52/reports/2010/VAOIG-09-03408-227.pdf>

Assessment I (Business Processes)

- Department of Veterans Affairs Office of Inspector General. (2012). Audit of VHA's Medical Care Collections Fund Billing of VA-Provided Care. Report No. 11-00333-254. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-00333-254.pdf>
- Department of Veterans Affairs Office of Inspector General. (2012). Review of Alleged Misuse of VA Funds to Develop the Health Care Claims Processing System. Report No. 14-00730-126. Retrieved from <http://www.va.gov/oig/pubs/VAOIG-14-00730-126.pdf>
- Department of Veterans Affairs Office of Inspector General. (2012). Review of Enterprise Technology Solutions, LLC Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations. (Report No. 12-01235-132). Retrieved from <http://www.va.gov/oig/pubs/VAOIG-12-01235-132.pdf>
- Department of Veterans Affairs Office of Inspector General. (2011). Review of Alleged Mismanagement of Non-VA Fee Funds at the Phoenix VA Health Care System. (Report No. 11-02280-23). Retrieved from <http://www.va.gov/oig/pubs/VAOIG-11-02280-23.pdf>
- Department of Veterans Affairs Office of Inspector General. (2010). Alleged Issues in Fee Basis Care, Martinsburg VA Medical Center, Martinsburg, West Virginia. (Report No. 10-02006-29). Retrieved from <http://www.va.gov/oig/54/reports/VAOIG-10-02006-29.pdf>
- Department of Veterans Affairs Office of Inspector General. (2010). Healthcare Inspection: Healthcare Inspection Review of Allegations of Coding and Billing Irregularities, VA Medical Center, Kansas City, Missouri. (Report No. 09-03418-68). Retrieved from <http://www.va.gov/oig/54/reports/VAOIG-09-03418-68.pdf>
- Department of Veterans Affairs Office of Inspector General. (2009). Alleged Mismanagement of the Fee Basis Program, VA Connecticut HealthCare System, West Haven, Connecticut. (Report No. 09-01219-141). Retrieved from <http://www.va.gov/oig/54/reports/VAOIG-09-01219-141.pdf>
- Department of Veterans Affairs Office of Inspector General. (2009). Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program. Retrieved from <http://www.va.gov/oig/52/reports/2009/VAOIG-08-02901-185.pdf>
- Department of Veterans Affairs Office of Inspector General. (2007). Review of Resident Supervision Documentation and Billing Practices in Veterans Health Administration Facilities. Report No. 05-0123-56. Retrieved from <http://www.va.gov/oig/54/reports/vaoig-05-01223-56.pdf>
- Department of Veterans Affairs Office of Inspector General. (2002). Audit of the Medical Care Collection Fund Program. Report No. 01-00046-65. Retrieved from <http://www.va.gov/oig/52/reports/2002/01-00046-65.pdf>
- Department of Veterans Affairs Office of Inspector General. (1998). Audit of the Medicare Care Cost Recovery Program. Report No. 8R1-G01-118. Retrieved from <http://www.va.gov/oig/52/reports/1998/8R1-G01-118.pdf>
- Department of Veterans Affairs Veterans Health Administration (2015). VHA (2015) Task Force on Improving Effectiveness of VHA Governance.

Assessment I (Business Processes)

- Department of Veterans Affairs Veterans Health Administration. (2014). Non-VA Medical Care Program Improper Payments Elimination and Recovery Improvement Act Audit.
- Department of Veteran Affairs VHA Directive 005 Timeliness Standards for Processing Non-VA Provider Claims. (2010). Retrieved from http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2157
- Department of Veteran Affairs VHA Directive 007 Pre-Registration (2007).
- Department of Veteran Affairs VHA Directive 025 Closeout of Veterans Health Administration Corporate Patient Data Files Includes Quarterly Inpatient Census. (2013). Retrieved from http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2419
- Department of Veteran Affairs VHA Handbook 1907.03 Clinical Coding Program Procedures. (2012). Retrieved from http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2794
- Government Accountability Office. (2014). Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit. Report No. GAO-14-175
- Government Accountability Office. (2014). Expanded Access to Non-VA Care through the Veterans Choice Program. Report No. GAO-15-229. Retrieved from <http://www.gao.gov/products/GAO-15-229R?source=ra>
- Government Accountability Office. (2014). Further Action Needed to Address Weaknesses in Management and Oversight of Non-VA Medical Care. Report No. GAO-14-696T. Retrieved from <http://www.gao.gov/products/GAO-14-696T>
- Government Accountability Office. (2014). Management and Oversight of Consult Process Need Improvement to Help Ensure Veterans Receive Timely Outpatient Specialty Care. Report No. GAO-14-808. Retrieved from <http://www.gao.gov/products/GAO-14-808>
- Government Accountability Office. (2013). Management and Oversight of Fee Basis Care Need Improvement. Report No. GAO-13-441. Retrieved from <http://www.gao.gov/assets/660/654979.pdf>
- Government Accountability Office. (2009). Ineffective Medical Center Controls Resulted in Inappropriate Billing and Collection Practices. Report No. GAO-10-152T. Retrieved from <http://www.gao.gov/products/GAO-10-152T>
- Government Accountability Office. (2008). Ineffective Controls Over Medical Center Billings and Collections Limit Revenue from Third-Party Insurance Companies. Report No. GAO-08-675. Retrieved from <http://www.gao.gov/products/GAO-08-675>
- Government Accountability Office. (2004). VA Medical Centers Further Operational Improvements Could Enhance Third-Party Collections. Report No. GAO-04-739. Retrieved from <http://www.gao.gov/products/GAO-04-739>
- Healthcare Financial Management Association. (2013). Relying on Your Denials Management Strategies for ICD-10. Retrieved from <http://www.hfma.org/denialsmanagementicd-10/>

Assessment I (Business Processes)

- Healthcare Financial Management Association. (2012). Revenue Cycle Key Performance Indicators (KPI) Definitions. pp 1-4.
- Heubusch, K. (2008). Coding's Biggest Challenges Today. Journal of AHIMA 79, no.7 (July 2008): 24-28. Retrieved from http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_039062.hcsp?dDocName=bok1_039062
- Kongstvedt, P. (2007). Essentials of Managed Care.
- Medicare Claims Processing Manual. General Billing Requirements Section 80.2. <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf>.
- National Academy of Public Administration (NAPA) White Paper. (2011). Veterans Health Administration Fee Care Program. Retrieved from http://www.napawash.org/wp-content/uploads/2011/11/White_Paper11012011webposting.pdf
- Palmetto GBA. Mandatory Claims Filing Requirements. (2014). Retrieved from <http://www.palmettogba.com/palmetto/providers.nsf/vMasterDID/8EEL6R1473>

Appendix F Acronyms

Table F10-1. List of Acronyms

Acronym	Description
AHIP	America's Health Insurance Plans
AHIP	AHIP
AITC	Austin Information Technology Center
ANSI	American National Standards Institute
AR	Accounts Receivable
ASC	Accredited Standards Committee
BI	Business Intelligence
CAC	Computer-Assisted Coding
CAMH	CMS Alliance to Modernize Healthcare
CAQH	CAQH
CBO	Chief Business Office
CBOC	Community Based Outpatient Clinics
CBOPC	CBO Purchased Care
CDI	Clinical Documentation Improvement
CFO	Chief Financial Officer
CMS	Centers for Medicare and Medicaid Services
COTS	Commercial, Off-The Shelf
CPAC	Consolidated Patient Account Centers
CPCPAC	Central Plains Consolidated Patient Account Center
CPRS	Computerized Patient Record System
CPT	Current Procedural Terminology
DMC	Debt Management Center
DME	Durable Medical Equipment
DNFB	Discharged Not Final Billed
DSS	Decision Support System
E&M	Evaluation and Management
ED	Emergency Department
EDI	Electronic Data Interchange
eIV	Electronic Insurance Verification

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Acronym	Description
EOB	Explanation of Benefits
FBCS	Fee Basis Claims System
FCCPAC	Florida and Caribbean Consolidated Patient Account Center
FMS	Financial Management System
FRT	Facility Revenue Technician
FSC	Financial Services Center
FTE	Full Time Equivalent
FWA	Fraud, Waste and Abuse
GAO	Government Accountability Office
GDRO	Gross Days Revenue Outstanding
HAC	Health Administration Center
HAS	Hospital Administration Services
HEC	Health Eligibility Center
HFMA	Healthcare Financial Management Associations
HIMS	Health Information Management Services
HRC	Health Resources Center
ICB	Insurance Capture Buffer
ICD-10	International Statistical Classification of Diseases and Related Health Problems Version 10
IPERIA	Payment Elimination and Recovery Improvement Act
IRS	Internal Revenue Service
IT	information technology
KPI	Key Performance Indicators
LTC	Long Term Care
MCCF	Medical Care Collections Fund
MAC	Medicare Administrative Contractors
MACPAC	Mid-Atlantic Consolidated Patient Account Center
MAS	Medical Administration Service
MCCF	Medical Care Collections Fund
MSCPAC	Mid-South Consolidated Patient Account Center
NCCPAC	North Central Consolidated Patient Account Center
NECPAC	North East Consolidated Patient Account Center

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

Assessment I (Business Processes)

Acronym	Description
OCR	Optical Character Recognition
OGC	Office of General Counsel
OGF	Other Government Facility
OHI	Other Health Insurance
OIG	Office of Inspector General
OPM	Office of Personnel Management
PAS	Patient Administration Services
PC3	Patient-Centered Community Care
PIT	Program Integrity Tool
PMO	Project Management Office
QIT	Quality Inspector Tool
ROI	Release of Information
SHRM	Society for Human Resources Management
SMART	Specific, Measurable, Achievable, Relevant, and Time Bound
SME	Subject matter experts
SOP	Standard Operating Procedures
SSA	Social Security Administration
TOP	Treasury Offset Program
TPA	Third Party Administrator
USC	United States Code
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice and Accountability Act
VAMC	VA Medical Centers
VCL	Veterans Choice List
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WCPAC	West Consolidated Patient Account Center

The views, opinions, and/or findings contained in this report are those of Grant Thornton and should not be construed as an official government position, policy, or decision.

This page intentionally left blank.