STATEMENT OF
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THE AMERICAN LEGION
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON
THE MEDICAL CARE COLLECTION FUND (MCCF)

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Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the Medical Care Collection Fund (MCCF). We commend the Subcommittee for holding a hearing on this important program.

Public Law 105-33, the Balanced Budget Act of 1997, established the Department of Veterans Affairs' (VA) MCCF and requires that amounts collected or recovered after June 30, 1997, be deposited into this fund. MCCF is a depository for funds collected from third-party reimbursements from private insurance plans, outpatient prescription copayments and other medical charges and user fees. The funds collected may only be used for providing VA medical care and services and for VA expenses for identification, billing, auditing and collection of amounts owed the Federal government.

Funds collected through MCCF are used as an offset rather than a supplement to annual discretionary appropriations for VA's medical care budget. The efficient and timely collection of these reimbursable costs greatly benefit the VHA in meeting the demands of an increasingly overburdened system. By off-setting these funds VA loses valuable funding that is not an accurate representation of the veterans' population in Veterans Equitable Resource Allocation (VERA) formula nor does it allow for the full utility of collecting from the nation's largest health insurance provider - Medicare.

Currently, VA distributes discretionary funds to its 21 Veterans Integrated Service Networks (VISNs) using the detailed VERA formula. Although VERA contains numerous allocation components, neither the number of enrolled Priority Group 7 and 8 veterans nor the number of enrolled Medicare-eligible Priority Group 7 or 8 veterans are allocation factors. Yet VA treats these veterans for nonservice-connected medical conditions with the expectation of collecting both co-payments and third-party reimbursements. When these Priority 7 or 8 veterans have no private insurance or list Medicare as their third-party insurer, VA cannot recoup the reasonable cost of care for the treatment of nonservice-connected medical conditions. Since over half of the current enrolled population consists of Priority Group 7 and 8 veterans, this is an extremely critical funding flaw.

These fundamental elements are crucial to improving MCCF's ability to improve the level of funding for VA health care. VA must have the ability to bill, collect and administrate more effectively a system established to help recover third-party reimbursements for the treatment of nonservice-connected medical conditions. MCCF needs to utilize a viable means to help VA effectively recover third-party reimbursements owed to VA. The use of model agencies' successful collection system, such as the Indian Health Services (IHS), can increase the efficiency of MCCF activities.

OFFSET OF MCCF TO DISCRETIONARY APPROPRIATIONS

Offsetting collections are monies that are deducted from outlays rather that counted on the receipt side of the budget. Outlays are the amount of money the Federal government actually spends in a given year. Offsets are often payments received for goods or services provided by the Federal government, such as medical care given to veterans by VA who are already covered under another health plan (public or private). The Debt Collection Improvement Act of 1996 (DCIA), Pub. L. 104-134, 110 Stat. 1321, (Apr. 26, 1996), as codified in 31 U.S.C. 3716(c), requires the Department of the Treasury (Treasury) and other disbursing officials to offset Federal payments to collect debts owed to the United States. This also applies to debts "owed" to the Treasury by Federal agencies that calculate offsets into discretionary budgets.

Technically, MCCF is not considered a Treasury offset because the funds collected do not actually go back to the MCCF Treasury account, but remain within VHA and are used as operating funds. Instead, in developing a budget proposal, it appears that the total appropriation request is reduced by the estimate for MCCF for the fiscal year in question. The American Legion fails to understand the difference in the net effect to the VISNs and VAMCs. Offsetting estimated MCCF funds largely defeats the purpose of realigning VHA's financial model to more closely approximate the private sector. The American Legion adamantly opposes offsetting annual VA discretionary funding by the MCCF recovery.

IMPROVING MCCF COLLECTIONS via INDIAN HEALTH SERVICES MODEL

Recent changes by the Veterans Health Administration (VHA) in the way medical care costs are recovered has had a dramatically positive effect on the amount of revenue collected. The implementation of the VHA Revenue Cycle Enhancement Plan in early FY 2002 resulted in significantly higher receipts than projected; so much so that VHA recently doubled the amount VA expects to receive in FY 2004 from $1.03 billion to $2.1 billion. However, MCCF system can benefit from agency models that clearly exemplify the efficiencies gained through practical application.

Five members of The American Legion's National staff visited IHS Headquarters in Rockville, MD to review and discuss the IHS experience with Medicare billing and collection. This was followed by a site visit by four National staff members to the Albuquerque Area Office of IHS for a detailed overview of the "Third Party Revenue Cycle." This was an extensive briefing on

the individuals, interactions and functions necessary to generate revenue collection, with a particular emphasis on the Medicare component. Afterward, three National staff traveled to the Acoma-Canoncita-Laguna (ACL) Hospital in San Fidel, NM for a demonstration of the billing and collection process.

BACKGROUND

IHS was established to meet the government's responsibility to provide health care to Native Americans. Like VA health care, it is not an "entitlement" program. Primary care is their basic mission, but they also deal with Public Health issues, such as sanitation. IHS treats about 1.5 million patients a year (based on use within the past three years) of a population census of 2.2 million. There are about 50 facilities, many of them small rural clinics.

In 1976, Congress enacted title IV of the Indian Health Care Improvement Act (IHCIA) which amended titles XIII (Medicare) and titles XIX (Medicaid) of the Social Security Act (SSA). This allowed IHS to bill for medical services provided by IHS facilities to Native Americans eligible for Medicare (Part A) or Medicaid. Billing for Medicare Part B was authorized in 2002.

Initially, there was cultural and bureaucratic resistance to the billing and collection of Medicare and Medicaid. In 1990, IHS collected only about $200,000. After absorbing significant cost increases that were never funded in FY 1992-1996, an emphasis was placed on collections for sheer survival. IHS now collects about $500 million a year. Of this, about $100 million is from Medicare billing. The bulk of collections come from Medicaid, which is consistent with the circumstances of the Native American population where, historically, there are lower incomes and shorter life spans.

FINDINGS

Medicare billing and collection has been successfully implemented within IHS. The benefits of successful implementation:

- ✓ Improved quality of care
- ✓ Accurate and complete medical documentation
- ✓ Enhanced provider profiling capabilities
- ✓ Reduced malpractice and tort action liability
- ✓ Improved Risk Management for physicians and hospitals
- ✓ Facilitated Quality Assurance
- ✓ Compliance with rules and regulations
- ✓ Third-party resource maximization

KEY ELEMENTS

In contrast to Department of Defense (DOD) Medicare Subvention Pilot Demonstration, IHS has no level of effort associated with its Medicare collection program. IHS collaborates with the Services Center for Medicare and Medicaid, (CMS) through an advisory group that deals with policy decisions. There must be "buy-in" from the top with leadership focused on and closely monitoring the process. There was an initial investment in training people, and there was a

learning curve in the business process, where there is a deliberate billing process that requires attention to detail. A major lesson learned was too much emphasis on the billing process rather than the collection of accounts receivable. Although billing is important, accounts receivable activities ultimately determine a successful collection rate.

Everyone in the process must understand their role. The training of coders is extremely important, and the coders should be certified. Pay grade of certified coders should be more comparable to the private sector for successful recruitment and retention purposes. IHS and DOD use electronic medical records that have the capability to generate billing information. It was suggested that software solutions are now available that make it feasible for VA to succeed in the business practice.

CONCLUSION

The Indian Health Service's experience with Medicare collections demonstrates that a Federal agency can successfully manage Medicare billing and collection. It further creates a blue print that is applicable to similar action by VA, when reimbursement is authorized. IHS has had a targeted goal for the use of its Medicare and Medicaid collections since inception: to improve the quality of care, in particular, as indicated by accreditation, such as, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO scores for the 2001 Corporate Survey of the six facilities within the Albuquerque IHS Area ranged from 92 to 97. All were above the national average score of 88. This would seem to indicate that success in the revenue collection program has correlated with success in meeting the accreditation goal.

IHS has a 10-year exemption (through 2004) from reporting to CMS the actual cost of care. IHS personnel have develop a process for capturing such data actually based on VA's data collection model.

The American Legion is pleased with the progress in collections that VHA has made to date. If VA is to provide timely access to quality care for veterans, MCCF must become a substantial portion of VHA's operating revenue. The American Legion supports the President's FY 2004 budget request's legislative initiative requiring Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) to consider VHA a network provider or preferred provider, respectively. This legislation would prevent HMOs and PPOs from using the lack of a participating network or preferred provider agreement as a reason for non-payment to VA for services provided for other than urgent conditions.

If VA can become a network provider or preferred provider for HMOs or PPOs, The American Legion wonders why VA can't become a designated Medicare provider, as well.

The American Legion also supports another legislative initiative in the President's FY 2004 budget request to require enrolled veterans to identify all of the public and private health insurance coverage to help facilitate VA's billing and collection activities.

MEDICARE REIMBURSEMENT TO MCCF

Medicare is a Federal health insurance program. Nearly every person is mandated, by law, to make monthly contributions to Medicare throughout his or her working career. Employees must pay 1.45 percent of taxable wages. The employer must match that amount, yet unlike Social Security, there is no cap. Therefore, the majority of beneficiaries make significant monetary contributions to Medicare before ever becoming eligible for coverage. The more money made by an individual, the higher the combined payment to Medicare. Medicare is a pyramid-based funding scheme – spreading out the risk among its ***potential*** beneficiaries and those who are actually receiving coverage. Medicare is considered an entitlement; therefore, it receives annual Federal mandatory appropriations.

Generally, any person is eligible for Medicare if:

- that person or their spouse worked for at least 10 years in a Medicare-covered employment,
- that person is 65 years of age or older, and
- that person is a citizen or permanent resident of the United States.

Others may qualify for coverage if:

- they are under age 65 with severe disabilities, or
- are diagnosed with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two basic components:

- Part A (Hospital Insurance) – basic coverage provided for allowable health care services.
- Part B (Medical Insurance) – additional coverage available on a premium basis for additional health care services.
- Supplemental Coverage – available through private insurance providers on a premium basis for charges not covered by Part A and Part B coverage.

Medicare offers certain choices to include:

- The original Medicare program, or
- Medicare+Choice including Medicare Managed Care Plans and Medicare Private Fee-for-Service Plans.

VHA is the largest Federal integrated health care delivery system. Eligibility for enrollment in VHA is based on honorable military service and limited by existing appropriations. Currently, there are 24 million veterans. Nearly 7 million are currently enrolled in VHA, but thousands of additional veterans are waiting to enroll. Currently, access to care is determined on a priority basis. Priority Group 1 has the highest priority to care, while Priority Group 8 has the lowest priority to enroll for care. Each Priority Group is clearly defined in Title 38, United States Code (USC).

Although access to VHA is an earned benefit, it is not considered an "entitlement"; therefore, funding is dependent upon annual discretionary appropriations rather than mandatory appropriations. Title 38, USC, identifies which veterans shall receive care at no personal cost. VHA is authorized to bill, collect, and retain all co-payments and third-party reimbursements.

Even though Medicare is one of the Federal health insurance programs, VHA is prohibited from billing or collecting third-party reimbursements. There is no logical explanation or justification for this prohibition in Title 38, USC, especially since IHS and DoD's TRICARE for Life include Medicare's fee-for-service model in their systems.

After Congress finalizes the budget process, VA has a structured formula for the internal distribution of its annual discretionary appropriations through VERA. This formula is based on specific components that determine exactly how much money will go to each of the 21 VISNs. Although the number of Medicare-eligible or Priority Group 7 and 8 veterans make up over half of VA's patient population, they are not actual funding components in determining distribution. The funding components are based on:

- Number of veterans requiring basic care (vested and non-vested);
- Number of veterans requiring complex care;
- Geographic Price Adjustment;
- Research Support;
- Education Support;
- Equipment Support; and
- Nonrecurring Maintenance.

The American Legion strongly supports allowing VA to bill and collect from CMS for the treatment of nonservice-connected disabilities of enrolled Medicare-eligible veterans.

As a Medicare provider, VHA would be authorized to bill and collect allowable third-party reimbursements from the Medicare Trust Fund for the treatment of nonservice-connected medical conditions of enrolled Medicare-eligible veterans. There are logical reasons to justify Medicare reimbursements:

- Centers for Medicare and Medicaid Services (CMS) determine Medicare-eligibility.
- All Medicare-eligible beneficiaries are free to choose their health care providers.
- Only military service determines eligibility for enrollment in VHA – Medicare-eligibility is not a factor.
- VHA is mandated by law to bill and collect third-party reimbursements for the treatment of nonservice-connected medical conditions of enrolled veterans, except from Federal health insurance programs like Medicare.
- VHA is an integrated health care delivery system providing a full continuum of health care services and treatments.
- IHS has successfully demonstrated how Medicare reimbursements can be successfully accomplished to improve the quality of care to beneficiaries.
- VHA does not receive adequate annual Federal discretionary appropriations to meet the health care needs of its growing patient population.
- Congressional oversight of CMS and VHA greatly reduces opportunities for fraud, waste, or abuse in billing or treatment of Medicare-eligible beneficiaries.
- The number of veterans enrolled in VHA is contingent upon existing appropriations, co-payments and third-party reimbursements.

The Medicare Trust Fund is funded to make reimbursements for quality health care delivered to beneficiaries by qualified Medicare providers. VHA, like IHS, provides quality health care to a unique patient population by using a combination of funding sources: discretionary appropriations and third-party reimbursements.

Mr. Chairman, in passing the Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. 104-262, Congress required VA to furnish hospital care and medical services to, among others, any veteran with a compensable service-connected disability or who is unable to defray the expenses of necessary medical care and services. It further authorized the VA, with respect to veterans not otherwise eligible for such care and services, to furnish needed hospital, medical, and nursing home care.

The overwhelming response from the veterans' population was largely unanticipated and badly under funded, leading to the recent suspension of Priority Group 8 veterans enrollment. The American Legion believes the VHA is on the right track to developing the fiscal means to comply with the Congress' intent to provide health care to all this nation's veterans. Allowing access to all available Federal and non-Federal funding sources and to achieve the efficiencies described above can only accelerate VA's compliance with that mandate.

Finally, The American Legion is deeply concerned about veterans with no private health insurance. The American Legion strongly recommends Congress consider authorizing VA to offer health benefit packages on a premium basis much like DoD's TRICARE program. When DoD was faced with meeting timely access standards for military retirees and dependents, it created TRICARE which offers premium-based health benefit packages based on the individual health care needs of its beneficiaries. The American Legion believes a similar benefit should be made available for Priority Group 7 and 8 veterans, especially those currently prohibited from enrolling. The funds collected through premium-based health care plans would provide a much needed additional revenue stream for an already over burdened system.

Thank you for this opportunity to present The American Legion views on this important topic. That concludes my testimony.