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BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS

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Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for the opportunity to further discuss the proposed improvements to the billing and reimbursement processes included in the Department of Veterans Affairs' (VA) plan to consolidate community care programs. To increase access to health care, VA plans to streamline the billing and reimbursement processes and implement system changes that will reduce frustration among community providers. I am accompanied today by Dr. Gene Migliaccio, Deputy Chief Business Officer for Purchased Care.

VA is committed to providing Veterans access to timely, high-quality health care. In today's complex and changing health care environment, where VA is experiencing a steep increase in demand for care, it is essential for VA to partner with providers in communities across the country to meet Veterans' needs. To be effective, these partnerships must be principle-based, streamlined, and easy to navigate for Veterans, community providers, and VA employees. Historically, VA has used numerous programs, each with their own unique set of requirements, to create these critical partnerships with community providers. This resulted in a complex and confusing landscape for Veterans and community providers, as well as VA employees.

Acknowledging these issues, VA is taking action as part of an enterprise-wide transformation called MyVA. MyVA will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. Included in this transformation is a plan for the consolidation of community care programs and business processes, consistent with Title IV of the *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015*, the VA Budget and Choice Improvement Act, and recommendations set forth in the *Independent Assessment of the*

Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs (Independent Assessment Report) that was required by section 201 of the *Veterans Access, Choice, and Accountability Act of 2014* (Choice Act).

On October 30, 2015, VA provided Congress with a possible plan for a New Veterans Choice Program (New VCP) that would include the consolidation of all purchased care programs. The New VCP will include some aspects of the current Veterans Choice Program established by section 101 of the Choice Act and incorporate additional elements designed to improve the delivery of community care.

Consistent with the principles outlined in New VCP report, VA plans to streamline clinical and administrative processes, including the billing and reimbursement process. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve community providers' experience with VA while also increasing Veterans' access to health care. Currently, many community providers face inaccuracies or delays in payments due to VA's decentralized and highly manual billing and reimbursement process. VA plans to streamline business processes and implement new solutions that allow for auto adjudication of claims processing.

Background

Efficient adjudication of claims processing is the key to effective billing and reimbursement processes. High-performing networks invest in centralized, scalable auto adjudication technology platforms and use simplified product and reimbursement rules to facilitate high levels of auto adjudication. This enables automation of most claims and only requires review of claims in question, reducing delays and errors in payments. While this type of technology investment will have significant up-front costs, efficiency gains, savings, and additional key analytic capabilities will be generated once the solution is complete.

Auto adjudication of claims is made possible by establishing standard rules and processes, and integrating with complete patient and provider data. Systems interoperability allows for flexibility, enabling organizations to quickly respond to regulatory and best practice changes. Modern claims platforms can model care outcomes, and identify fraud, waste and abuse through data analytics. Industry

standards do not require the receipt of medical records for payment. VA does have this requirement, which often causes delays in payment. Within the health plan industry, private health providers submit claims using a standard format which typically includes patient information, services provided, and authorization if an authorization was required and obtained. Medical information is provided directly to the referring provider either through a patient summary or electronically. As VA improves claims processing, VA will no longer require medical records for reimbursement. VA will strive to improve the automation of systems to process medical records and conduct retrospective audits to confirm their receipt and develop lessons learned to support continuous improvement.

Current State

The current VA claims infrastructure and claims process are complex and inefficient due to highly manual procedures. VA also lacks a centralized data repository to support auto adjudication. There are more than 70 centers processing claims across 30 different claims systems, resulting in inconsistent processes. Limited automation and manual matching of claims to authorizations prevents efficient adjudication. Low electronic data interchange (EDI) claims submission rates, decentralized and inconsistent intake processes, and limited staff productivity standards (i.e., workload metrics) result in labor-intensive, paper-based processes that generate late, and sometimes incorrect payments. In FY 15, errors were determined in six improper payment categories: duplicate payment, goods or services not received, incorrect amount, ineligible good or service, ineligible recipient and lack of documentation. The overall improper payment rate for Fiscal Year 15 was 54.77%(the error rate excluding acquisition findings would be 12.42%). The majority of error findings were identified following the evaluation of payment compliance with the VAAR and the FAR which was an expansion of the audit scope from FY 14, but does not correspond to an increase in instances where the wrong provider was paid, the wrong amount was paid, a duplicate payment was made or services were not received.

Claims Processing Actions/Strategies Implemented for Improvement

VA has already taken many steps to improve timeliness of payment to community providers. To increase transparency in the claims inventory, VA implemented a claims inventory dashboard allowing VA to monitor claims in near real time, including:

- Backlog details –inventory by age, type of claim, and where claims are in the processing cycle
- Monitor processing strategy - aged claims and "cliff" or claims about to age
- Monitor staff and contractor productivity
- Monitor incoming and processed trends

VA established deep dive calls with Veterans Integrated Service Networks (VISNs) facing the largest backlogs. These calls occur several times per week and involve support staff in the review of data/dashboard, production, barriers, and staffing issues. The calls focus on site action plans for addressing the backlog, eliminating barriers and monitoring productivity, processes and trends. Furthermore, VA established weekly workload calls to specifically align support teams, work through local payment center issues and VISN issues, and address barriers to maximize improvement and contract support.

To reduce aged claims, VA implemented of backlog strategy based on claim type and priorities, such as processing backlog claims and claims that are about to age and contribute to the backlog first. These claims are monitored on a daily basis so that corrections can be made when needed. Additionally, VA implemented claims processing performance standards which have been communicated in performance plans.

Currently, VA is deploying a strategy to realign resources within each VISN and then nationally to ensure that resource allocation is consistent with need. VHA has ongoing communications with VAMC facility leadership to reduce and eliminate facility barriers to prompt payment such as ensuring timely entry of authorizations.

As stated during the HVAC hearing in June 2015, VA would fill over 200 vacancies within 90 days of the hearing. VA exceeded that goal by hiring over 200 staff within eight weeks.

VA has also improved outreach efforts with stakeholders. VA is identifying better and more frequent ways to communicate the status of claims processing timeliness with community providers, Members of Congress, and Veterans. Ongoing training is being provided to community providers on the resources available to address issues identified by the provider accounts receivables reports, to include monthly calls held with providers to address account claim concerns. VA is meeting with State Hospital Associations across the country to educate them on claims processing, Veteran authorities for payment of claims, and local claims status.

These recent actions have had a significant impact on processing volume. In fiscal year (FY) 2015, VHA processed 16,793,057 claims representing a 21 percent increase over the same period the year before, when VHA processed 13,256,119 claims. As of January 15, 2016, Community Care claims inventory is 72.08 percent current, with a total claims volume at 1.8 million claims.

VA continues to experience tremendous growth in the volume of claims for care provided by community providers. VHA has received 22 percent more claims from October 2014 through September 2015 compared to the same period in the prior year. VHA staff makes every effort to ensure claims are processed timely. Our current standard is to have at least 85 percent of our claims inventory current, which means under 30 days old for “clean” claims and under 45 days old for “other than clean” claims. A “clean claim” is a claim that has no defect or impropriety, such as a coding error.

Future State

VA will pursue a claims solution and simplify processes as it evolves to achieve parity with best practices. Consistent with the principles in the New VCP plan, VA will focus on:

- Standardizing business rules and logic to support claims processing;
- Improving reimbursement processes by removing the requirement for providers to submit medical records as a condition of payment;
- Improving interfaces and coordination with dependent systems; and

- Implementing reimbursement models to recognize and promote Connected Health activities, such as outreach to Veterans for self-help, health promotion and secondary prevention, telehealth, team-based care, and Veteran education.

In the long term, VA will use a scalable, flexible claims platform that supports emerging value-based care models and streamlines data maintenance, storage, and retrieval. This new claims solution will support VA's efforts to reduce waste, fraud, and abuse. In addition, the VA claims solution will integrate with Veteran Eligibility Systems, Authorization Systems, and standardized fee schedules to support auto adjudication. Integration with fee schedules will support new payment models and enable better tracking and billing integration with other health insurance (OHI). VA will also integrate the claims processing system with patient information, increasing VA's ability to efficiently bill OHI. Taken together, the new claims solution will allow VA to pay on time and correctly while meeting Prompt Payment Act compliance. VA protects Veteran identifiable information in its IT systems via secure networks. VA will coordinate referral management with tracking financial obligations to provide the basis for resource and process adjustments based on forecasted versus actual use of funds.

VA will determine whether to improve the system through the adoption of a new one or by purchasing the required capabilities externally. VA will oversee adherence to business rules, standardize internal controls, and have proper access to systems holding information to be reviewed. Keeping in line with best practices, VA will conduct claims audits for accuracy. VA also will provide compliance oversight for the new Prompt Payment compliance process owner in accordance with VA Directives, Handbooks, and other applicable policies. To monitor and improve performance of billing and reimbursement, VA will use industry standards as metrics for continuous process improvement.

Conclusion

VA is continuing to examine how the existing Veterans Choice Program interacts with other VA health programs. In addition, VA is evaluating how it will adapt to a rapidly changing health care environment and how it will interact with other health

providers and insurers in the future. As VA continues to refine its health care delivery model, we look forward to providing more detail on how to convert the principles outlined in this plan into an executable, fiscally-sustainable future state. In addition, VA plans to review feedback and potentially incorporate recommendations from the Commission on Care and other stakeholders.

In the meantime, VA will implement improvements to the delivery of community care through an incremental approach as outlined in the plan, building on certain provisions of the existing Veterans Choice Program. The implementation of these improvements requires balancing care provided at VA facilities and in the community, and addressing increasing health care costs. VA will work with Congress and the Administration to refine the approach described in this plan, with the goal of improving Veteran's health outcomes and experience, as well as maximizing the quality, efficiency, and sustainability of VA's health programs. These improvements, like many of the enhancements VA has already made, are only possible with Congressional support, including legislation and necessary funding.

VA strongly values its relationship with our community providers. We realize the vital role they play in assisting us in providing timely and high-quality care to Veterans. We are working hard to expedite payments and streamline our claims services in order to make this an effective and efficient process for all.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other Members of the Committee may have.