

HCFE Data Brief

HCFE DB# 2004-07

AN INITIAL MODEL OF POTENTIAL COLLECTIONS UNDER REASONABLE CHARGES

John A. Gardner, PhD

Ann M. Hendricks, PhD

November 23, 2004

This work was funded by the Department of Veterans Affairs, Veterans Health Administration, Health Services Research and Development Services. This report presents the findings and conclusions of the authors and does not represent the opinions of VA or HSR&D.



Health Care Financing & Economics

VA Boston Health Care System Research & Development
150 South Huntington Avenue (Mail Stop 152H), Boston, MA 02130 • Phone: (617) 232-9500 Ext. 6058 • <http://www.hcfe.org>

Under PL105-33, the Veterans Health Administration (VA) began billing insurers for reasonable charges for care and services provided rather than on the basis of reasonable cost. Under an agreement with the Revenue Office, the HSR&D Management Decision and Research Center contracted with the HSR&D Center for Health Quality, Outcomes and Economic Research (CHQOER) to estimate the potential collections available to the VA for FY2000 under the reasonable charges approach. The reasonable charges model, in comparison with the previous reasonable cost model, also includes improved insurance rate data and collection estimates. This Data Brief provides the estimates for potential collections and summarizes the reasons that these estimates differ from estimates using earlier data and methods. The full report (available from the authors) provides the details of the new methods and data used.

Estimated potential collections

Using annualized first quarter FY2000 data, we estimated potential collections for the reasonable charges model for FY2000 to be about \$826 million. This amount compares with an estimate of about \$610 million for the reasonable cost model for the same period. Most of the difference (\$189 million) occurs in potential collections for inpatient stays for privately insured veterans. Estimated potential collections from outpatient care are \$35 million lower in the reasonable charges model than in the reasonable cost model.

Major differences between the reasonable charges model and the reasonable cost model

Per diems keyed to DRGs. For veterans with private insurance (other than Medicare supplemental coverage), the amount billed for inpatient services is a per diem keyed to DRGs instead of the bedsection. This change more than doubled the average per diem. By itself, this change would increase estimated potential collections by more than \$300 million, and is the largest single source of difference in estimated potential collections. The differences are greatest for medical and surgical intensive care.

Limit (for the model) on maximum inpatient days billed. The new model limited the number of days of care billed in an effort to approximate the limit insurers typically impose for each DRG; the previous model had no limit on the number of days. This limit, estimated from Medicare data, reduced billed days by almost half and lowered estimated potential collections from these services to 57% of what they otherwise would be. The largest impact was on potential collections for treatment for psychological conditions or substance abuse.

Billing outpatient services by CPT codes. Under reasonable charges, each CPT procedure had its own charge rate, and with some exceptions, each procedure performed was billed. Under reasonable cost, each visit was billed at a flat amount, regardless of the number or type of services provided. This change by itself would increase estimated annual potential collections by about \$40 million.

New insurance estimates. The estimated rates of insurance among veterans, drawn from the Office of Quality Improvement's 1999 Large Survey of Veterans, were considerably higher than previously used rates. The share with Medicare supplemental insurance was sharply higher: 27.6% for inpatient services and 28.2% for outpatient services, compared to previous estimates of 12.8% and 17.3%, respectively. The share of veterans with other

private insurance was also higher: 12.8% and 15.3% compared to 10.3% and 12.8% for inpatient and outpatient services, respectively. The higher rates raised estimated potential collections directly in proportion to their increases.

New estimated collection rates. For inpatient services provided to privately insured veterans, estimated collection rates were 83.8% compared to previous estimates of 58.0%. For outpatient services, the rates were 57.0% compared to 37.1%. These higher rates have direct, proportional effects on estimated potential collections. The rates are based on payor rates developed for VA by a private contractor from a database of 700 private employer health plans.

Adjusting some outpatient bills to Medicare-allowable amounts. For outpatient physician services provided to patients with Medicare supplemental insurance, estimated charges were divided by 1.74 to reduce them to Medicare-allowable amounts.

Services delivered by non-billable providers. Professional services can be billed only for types of providers listed in the *Federal Register* under the published rule. The outpatient data maintained at Austin do not record the type of provider. Following an agreement between CHQOER and the Revenue Office, the model reduced the calculated potential collections from outpatient services by 40% to estimate the percentage of services delivered by providers not listed in the *Federal Register*.

Limitations and qualifications

Some of the limitations and qualifications to the previous reasonable cost model also apply to the reasonable charges model:

- The model projects potential collections, not actual collections. The models have never attempted to portray the complications of the actual collection process.
- The extents of insurance and membership in HMOs are estimated as percentages applied to the entire VA workload. The data do not tell us which individual patients have insurance.
- The model assumes that the mix of care is the same for insured patients as for uninsured patients and is the same for those with Medicare supplemental insurance as for those with other private insurance.
- The model cannot allow for the specific details of insurance coverage or for limitations on coverage (such as limits on the number of days for mental health care).

Other limitations or qualifications are new and specific to the reasonable charges model:

- The 1999 Large Survey of Veterans, the source of our estimates of the extent of insurance among veterans, is new. No body of studies exists to validate the Survey's consistency with other data. Initial exploration suggests that the Survey's rate of Medicare enrollment is consistent with HCFA data for VISNs 1 and 2. Additional analysis in other subtasks of this project will partially validate Survey information.
- The Revenue Office has not determined reasonable charges for HCPCS level II CPT codes and some other codes. Dental services, prosthetics, and some supplies and equipment are currently being charged by each station at its own cost. Our estimates do not include these types of services.

- Potential collections are not estimated for inpatient physician charges that are not bundled with the DRG. The current data sets available from Austin do not identify these services.
- VA reasonable charges may often be higher than many insurers' allowable rates, causing payor rates produced by the outside contractor to overstate likely potential collection rates. VA rates for reasonable charges were deliberately set at a high percentage (80%) of each geographic market's reasonable and customary charges so that amounts charged would not often fall below amounts that higher-paying insurers normally paid. For inpatient stays, the new model partially addresses this problem by limiting the maximum number of days billed for each DRG. For outpatient services provided to veterans with Medicare supplemental insurance, an adjustment is also made, as described above.