

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Veterans Health Administration

*Audit of  
the Timeliness and  
Accuracy of Choice  
Payments Processed  
Through the Fee Basis  
Claims System*

December 21, 2017  
15-03036-47

# ACRONYMS

CCN	Community Care Network
CFR	Code of Federal Regulations
CLIN	Contract Line Item Number
CPT	Current Procedural Terminology
DAIC	Department of Audits and Internal Controls
EOB	Explanation of Benefits
FBCS	Fee Basis Claims System
FSC	Financial Services Center
FY	Fiscal Year
GAO	Government Accountability Office
MCCF	Medical Care Collection Fund
OCC	Office of Community Care
OHI	Other Health Insurance
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
SOP	Standard Operating Procedure
SLA	Service Level Agreement
TPA	Third Party Administrator
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VCP	Veterans Choice Program
VHA	Veterans Health Administration

**To report suspected wrongdoing in VA programs and operations,  
contact the VA OIG Hotline:**

**Website: [www.va.gov/oig/hotline](http://www.va.gov/oig/hotline)**

**Telephone: 1-800-488-8244**



# EXECUTIVE SUMMARY

---

## Why We Did This Audit

Public Law 113-146 (August 7, 2014), Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Section 101(o), requires the Inspector General of the Department of Veterans Affairs to issue a report to the Secretary of VA within 30 days after the Secretary's determination that 75 percent of the amounts deposited in the Veterans Choice Fund established by VACAA (the "Choice Fund") have been exhausted.<sup>1</sup> The report was to address "the results of an audit of the care and services furnished under this section to ensure the accuracy and timeliness of payments by the Department for the cost of such care and services, including any findings and recommendations of the Inspector General."

This report covers the audit of payments made through VA's Fee Basis Claims System (FBCS), encompassing claims paid via that payment process from November 1, 2014 through September 30, 2016. A subsequent report will contain the results of an audit conducted to assess VA's processing of payments through a "bulk payment" process during 2016 and 2017.

## Background

On August 7, 2014, following well-publicized issues regarding delays in accessing care at VA medical centers (particularly in Phoenix, Arizona), Congress enacted VACAA, which set forth a broader program (the "Choice Program") to enable eligible veterans to obtain medical care from providers in their communities.<sup>2</sup> Congress appropriated \$10 billion to the Choice Fund to be spent on care and expenses specifically authorized under VACAA, including \$300 million for administrative expenses associated with establishing and maintaining the Choice Program. VACAA required VA to implement key portions of the Choice Program within 90 days, and veterans began using the Choice Program by November 2014.

VA's Office of Community Care (OCC), which is part of the Veterans Health Administration (VHA) and is under the leadership of the Deputy Under Secretary for Health for Community Care, is responsible for the administration and operation of the Choice Program.<sup>3</sup> VA's Patient-Centered Community Care program (PC3) is a nationwide program for delivering care in the community established in 2013. In October 2014, VA amended the PC3 contracts with Third

---

<sup>1</sup> The VA Office of Inspector General, pursuant to the requirement in Public Law 113-146, released on September 12, 2017 to the Secretary of Veterans Affairs a memorandum titled "Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act."

<sup>2</sup> Public Law 113-146 (August 7, 2014), Veterans Access, Choice, and Accountability Act of 2014. Eligibility for Choice is based on specific criteria relating to wait times for appointments and distance from the nearest medical facility, and these eligibility requirements have been modified on occasion by statute and regulation.

<sup>3</sup> OCC, the group managing Choice, was known as the Chief Business Office until October 2016, when it reorganized into the Office of Community Care. Regardless of time frame, this group will be referred to as "OCC."

Party Administrators (TPA) Health Net Federal Services LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) to include administration of the Choice Program, including establishing provider networks, scheduling appointments, receiving medical documentation, and making payments for medical care on behalf of VA.

Under the PC3/Choice contracts, VA makes payments to the TPAs, not the providers. The TPAs are responsible for paying their providers. VA reimburses the TPAs for payments the TPAs make to providers for veterans' medical care obtained through the Choice Program. TPAs' billings are submitted to OCC electronically, and then processed by VA's Financial Services Center (FSC) in Austin, Texas. During the period of review for this audit, the FSC processed Choice claims using FBCS.

## What We Did

Choice payment data were obtained from VA's Central Fee Files and statistically sampled for each TPA. Our audit included Choice claims processed in FBCS for payment to the TPAs from November 1, 2014 through September 30, 2016. We did not audit bulk Choice medical payments processed outside of FBCS,<sup>4</sup> Choice administrative payments, or payments for Hepatitis C and other non-Department care that used Choice Program funding.

We reviewed a sample of payment transactions from the approximately \$649 million paid to Health Net (\$69 million) and TriWest (\$580 million) from November 1, 2014 through September 30, 2016, via FBCS.<sup>5</sup> We reviewed the PC3/Choice contracts and interviewed officials from OCC, FSC, the Denver Acquisition and Logistics Center, Health Net, and TriWest. We used a third-party vendor to evaluate medical claims in our audit sample to determine if the Medicare rates applied were correct.

## What We Found

We estimated that from November 1, 2014 through September 30, 2016, payment errors were made on approximately 224,000 of 2.0 million Choice claims (12 percent)<sup>6</sup> paid via FBCS.

These errors were of the following types:

**Payment rate** - Payments made on claims that did not use the appropriate Medicare or contract adjusted rate

---

<sup>4</sup>PC3/Choice contracts were modified in March through November 2016 to allow VCPBYPASS (payments for Choice medical claims that were not submitted to VA by the TPAs due to missing medical documentation) and Expedited payments for Choice medical care to TPAs. We refer to these transactions as "bulk payments" for the purpose of our report. Because these bulk payment processes were not in place when this review was planned, a second audit was started in April 2017 to address the accuracy of payments under the bulk payment process.

<sup>5</sup>FBCS is the current claims processing system used for processing and payment by VHA of claims authorized under the non-VA Care Program which does not include PC3 or Choice claims.

<sup>6</sup>All payment error rates presented in this report are based on projections for a randomly selected sample; see Appendix C *Statistical Sampling Methodology* for more details.

**Other Health Insurance (OHI)** - Payments made on claims that were not adjusted for the amount OHI was responsible to pay the provider

**Duplicate** - Payments for medical claims that were submitted and paid more than once

**Pass-Through** - Payments where the amount the TPAs billed and were paid was more than the TPA paid the provider

We estimated that OCC payments to TPAs for approximately 1.0 million of 2 million claims (50 percent) were made in excess of the 30-day Prompt Payment Standard from November 1, 2014 through September 30, 2016.

We also estimated that Health Net took 47 days on average to pay its providers from November 1, 2014 through September 30, 2016. TriWest averaged 39 days to pay its providers for the same period.

## Why This Occurred

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) defines internal control standards for Federal Government agencies through five components consisting of 17 key principles necessary to produce an effective internal control system. In our review of the OCC Choice payment process, we found several internal control weaknesses in the payment process that contributed to the errors discussed in this report. We concluded that OCC did not design an effective internal control system for the Choice payment process and did not appropriately follow these internal control principles:

- Create clear written policy for the payment of claims
- Ensure access to quality information is available for payment processing staff
- Use a well-designed information system to address the risk of overpaying medical claims
- Establish monitoring activities to ensure internal controls are working

OCC's payments averaged 37 days to Health Net and 36 days to TriWest. These payment delays occurred because OCC did not accurately estimate the amount of staff necessary to process Choice claims through their Service Level Agreement with FSC. In addition, although VACAA requires VA to meet the timeliness standards of the Prompt Payment Act in paying the TPAs, the PC3/Choice contracts do not specify a timeliness standard applicable to the TPAs for their payments to providers.<sup>7</sup>

---

<sup>7</sup> Public Law 113-146 (August 7, 2014) Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Section 105(b)(1) and (2). VACAA requires VA to establish a claims processing system that complies with all requirements of the Prompt Payment Act, 5 CFR part 1315 – Prompt Payment.

## What Resulted

OCC failed to comply with VACAA regulations when it established payment processing systems that did not function efficiently and have proper controls to ensure payment accuracy. TPAs improperly billed OCC, and OCC made an estimated 224,000 payment errors when paying the TPAs because OCC did not have in place an effective internal control system for the Choice payment process to ensure Choice payment accuracy. These payment errors resulted in an estimated overpayment of about \$39 million during our period of review.

OCC did not implement an efficient claims processing system for Choice claims or adequately estimate staffing levels in the Service Level Agreement with FSC so that resources could be allocated in advance to deal with the Choice claims volume demand. Without such a system, OCC will continue to be at risk of late payments and penalty interest charges. Additionally, until OCC adds a standard for Choice payment timeliness to the PC3/Choice contracts for Health Net and TriWest, OCC will not have a control in place to enforce timely payments to Choice providers.

## What We Recommended

We made these recommendations to the Executive in Charge, Veterans Health Administration:

- Develop and issue written payment policies to guide staff processing medical claims received from TPAs as well as establish expectations and obligations for the TPAs that submit invoices for payment.
- Ensure payment processing staff have access to documentation from the TPAs verifying amounts paid to providers to ensure the TPAs are not billing VA more than they paid the provider for medical claims.
- Ensure VHA payment processing staff have access to accurate data regarding veterans' OHI coverage and establish appropriate processes for collecting payments from these health insurers.
- Ensure the new payment processing systems used for processing medical claims from TPAs have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.
- Ensure VA performs post-payment audits on a periodic basis to determine if payments made to TPAs for medical care are accurate.
- Ensure OCC staff and members of VA's Office of General Counsel continue to work collaboratively with relevant government authorities to review and determine an appropriate process for reimbursement.
- Ensure VHA has sufficient claims processing capacity to timely meet and process expected claim volume from the TPAs.
- Ensure that future contracts with TPAs contain payment timeliness standards for the processing of claims from health care providers.

## Agency Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with our findings and agreed that a full review of payments made under the Veterans Choice Program and recovery of all identified overpayments is essential. The Executive in Charge stated that VHA has already taken action to identify past duplicate payments and prevent future duplicate payments to TPAs beginning in July 2017 and plans to continue working collaboratively with the Office of Inspector General (OIG) and all other relevant government stakeholders to ensure that Choice payments are thoroughly reviewed and all overpayments are recovered.

The Executive in Charge concurred with Recommendations 1, 3, 5, 6, 7, and 8 and concurred in principle with Recommendations 2 and 4. Regarding Recommendations 2 and 4, VHA will address the documentation requirement in the upcoming Community Care Network contract. The Executive in Charge's planned corrective actions are acceptable. The OIG will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.



**LARRY M. REINKEMEYER**  
Assistant Inspector General  
for Audits and Evaluations

# TABLE OF CONTENTS

Introduction.....	1
Results and Recommendations .....	11
Finding 1    Twelve percent of Choice Claims Paid via FBCS Were Paid in Error .....	11
Recommendations .....	26
Finding 2    OCC Did Not Pay TPAs in Accordance With the Prompt Payment Act.....	28
Recommendations .....	31
Appendix A    Background .....	33
Appendix B    Scope and Methodology.....	36
Appendix C    Statistical Sampling Methodology .....	38
Appendix D    Potential Monetary Benefits in Accordance With Inspector General Act Amendments.....	47
Appendix E    Management Comments.....	48
Appendix F    OIG Contact and Staff Acknowledgments.....	55
Appendix G    Report Distribution.....	56



## INTRODUCTION

### Objective

Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014 (VACAA)*, Section 101(o), requires the Inspector General of the Department of Veterans Affairs to issue a report to the Secretary of VA within 30 days after the Secretary's determination that 75 percent of the amounts deposited in the Veterans Choice Fund established by VACAA (the "Choice Fund") have been exhausted.<sup>8</sup> The report was to address "the results of an audit of the care and services furnished under this section to ensure the accuracy and timeliness of payments by the Department for the cost of such care and services, including any findings and recommendations of the Inspector General."

This report covers the audit of payments made through VA's Fee Basis Claims System (FBCS), encompassing claims paid via that payment process from November 1, 2014 through September 30, 2016. Prior to the completion of our audit work, the Office of Community Care (OCC) significantly changed the manner in which it processed and paid Choice claims, which necessitated a second audit covering the "bulk payment" process, as described herein. The results of this audit will be published in a separate report.

### Program Background

VA, for a number of years, has had programs in place to enable veterans who could not receive care from VA to receive medical care and services from providers in their communities. These programs have included the non-VA care program, and the Patient-Centered Community Care (PC3) program.<sup>9</sup>

On August 7, 2014, following well-publicized issues regarding delays in accessing care at VA medical centers (particularly in Phoenix, Arizona), Congress enacted VACAA, which set forth a broader program (the "Choice Program") to enable eligible veterans to obtain medical care from providers in their communities.<sup>10</sup>

---

<sup>8</sup> The VA Office of Inspector General, pursuant to the requirement in Public Law 113-146, released on September 12, 2017 to the Secretary of Veterans Affairs a memorandum titled "Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act."

<sup>9</sup> PC3 is a nationwide program that uses service contracts to provide health care for eligible veterans when the local Veterans Health Administration medical facility determines that it cannot serve the veteran because of a lack of available specialists, long wait times, or geographic distance.

<sup>10</sup> Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014*. Eligibility for Choice is based on specific criteria relating to wait times for appointments and distance from the nearest medical facility, and these eligibility requirements have been modified on occasion by statute and regulation.

Congress appropriated \$10 billion to the Choice Fund to be spent on care and expenses specifically authorized under VACAA, including \$300 million for administrative expenses associated with establishing and maintaining the Choice Program. VACAA required VA to implement key portions of the Choice Program within 90 days, and veterans began using the Choice Program by November 2014. VA was authorized to provide care under this statute until the Choice Fund was exhausted, or three years after enactment, whichever occurred first. This ensured a sunset date of August 7, 2017 or earlier.<sup>11</sup>

VA's OCC, which is part of the Veterans Health Administration (VHA)<sup>12</sup> and is under the leadership of the Deputy Under Secretary for Health for Community Care, is responsible for the administration and operation of the Choice Program.

VACAA contains several provisions relating to payment of claims for services under the Choice Program. Section 101(k) requires the Secretary to "provide for an efficient nationwide system for processing and paying bills or claims for authorized care and services furnished to eligible veterans" and provided that regulations implementing this system must be prescribed within 90 days. Section 101(k)(4)(B) requires the quarterly submission of reports regarding the accuracy of this payment system to the House and Senate Committees on Veterans' Affairs. Section 105 of VACAA, titled "Prompt Payment by Department of Veterans Affairs," mandates prompt payment for claims for medical and health care services under the Choice Program, and that section required the Comptroller General to provide a report on the timeliness of payments one year after the enactment of VACAA.<sup>13</sup>

Section 201 of VACAA required that VA obtain an independent assessment of VA's health care delivery systems and processes. That report was delivered to Congress on September 1, 2015 (the "Independent Assessment").

On July 31, 2015, Congress enacted the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 (also known as the VA Budget and Choice Improvement Act). In part, that legislation authorized VA to use Choice funds for other kinds of care, such as treatment for

---

<sup>11</sup> *Ibid*, Section (101)(p)(2).

<sup>12</sup> OCC, the group managing Choice, was known as the Chief Business Office until October 2016, when it reorganized into the Office of Community Care. Regardless of time frame, this group will be referred to as "OCC."

<sup>13</sup> The report, "*Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers*," GAO-16-353, published by GAO in May 11, 2016 (the "GAO Report"), found significant delays in payments attributable to VHA's manual processing systems and recommended a written plan for modernizing the claims processing system.

Hepatitis C and other non-Department care, and it expanded the eligibility requirements for the Choice Program. It also required VA to develop a plan to consolidate all non-VA community care programs under Choice and to address a number of elements relating to payment of claims, such as “the structuring of the billing and reimbursement process, including the use of third-party medical claims adjudicators or technology that supports automatic adjudication.”<sup>14</sup>

In compliance with that requirement, OCC submitted to Congress a “Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care” in October 2015. VA’s proposals for the future version of its community care programs, including Choice, which VA refers to as the “Veterans CARE (Coordinated Access & Rewarding Experiences) Program,” are under consideration by Congress.

In April 2017, VACAA was amended to eliminate the Choice sunset date (August 7, 2017), allowing the Choice Program to operate until all of the money deposited in the Choice Fund is expended. VACAA was also amended to make VA the primary payer for medical care relating to non-service connected disabilities, which places upon VA the burden of recovering certain costs from third parties, such as veterans’ other health insurance (OHI) providers.<sup>15</sup> On August 12, 2017, Congress passed legislation approving \$2.1 billion in additional funding for Choice, which shall remain available until expended.<sup>16</sup>

---

<sup>14</sup> Public Law 114-41 (July 31, 2015), *Surface Transportation and Veterans Health Care Choice Improvement Act of 2015*, Section 4002(a) and (b)(4).

<sup>15</sup> Public Law 115-26 (April 19, 2017).

<sup>16</sup> Public Law 115-46 (August 12, 2017), *VA Choice and Quality Employment Act of 2017*, Section 101.

Table 1 summarizes Choice obligations and spending from fiscal quarters beginning in October 1, 2014 through June 30, 2017.

**Table 1. Obligations and Expenditures Through September 2017**

Funding Use	Obligated	Spent
Choice Administrative and Information Technology	\$436 million	\$342 million
Choice Medical Care	\$7.7 billion	\$5.9 billion
Hepatitis C and Other Non-Department Care	\$2.3 billion	\$2.3 billion
<b>Total*</b>	<b>\$10.5 billion</b>	<b>\$8.6 billion</b>

Source: Financial Management System 887 Obligations and 827 General Ledger reports Choice Appropriation obligation and disbursement totals as of September 30, 2017.

\*Table results are rounded numbers. As a result, columns do not sum exactly to the total.

**Requirements for Payment Processing**

Section 101(k)(1) of VACAA requires the Secretary to “provide for an efficient nationwide system for processing and paying bills or claims for authorized care and services furnished to eligible veterans under this section,” and mandates that regulations be prescribed for the implementation of this section in 90 days.<sup>17</sup> The Chief Business Office (now the Office of Community Care) was to oversee the implementation and maintenance of the payment system,<sup>18</sup> and the Secretary was required to ensure the claims processing system meets goals to be specified by the Secretary for the accuracy of payments.<sup>19</sup> The Secretary was further required to submit Quarterly reports to the Senate and House Veterans Affairs Committees on the accuracy of the claims processing system.<sup>20</sup>

The required regulations to implement the Choice Program are contained at 38 Code of Federal Regulations (CFR) 17.1500 through 17.1540. Most relevant is 38 CFR 17.1540, titled *Claims Processing System*, which states, “...The claims processing system will provide accurate, timely payments for claims received in accordance with sections 17.1500 through 17.1540.”<sup>21</sup> 38 CFR 17.1535, titled *Payment Rates and Methodologies*, requires the negotiation of rates per the statute and imposes primary responsibility for payment for services for non-service connected care upon veterans’ health

<sup>17</sup> Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014* (VACAA), Section 101(k)(2).

<sup>18</sup> *Ibid*, Section 101(k)(3).

<sup>19</sup> *Ibid*, Section 101(k)(4)(A).

<sup>20</sup> *Ibid*, Section 101(k)(4)(B).

<sup>21</sup> 38 CFR § 17.1540, *Claims processing system*.

insurance. The regulations provide no further detail on how the payment processing system is to be implemented or maintained.

The Independent Assessment conducted in 2015 included this discussion of VA's systems for making claims payments:

*VHA's claims payment activities are similarly burdened by lack of automation, multiple systems that are not integrated, and a significant amount of manual work. Specifically, automation is lacking in VHA's primary claims system, Fee Basis Claims System (FBCS), requiring VHA staff to scan the majority of the paper claims into FBCS and manually adjudicate claims. In addition, non-VA providers do not have visibility into the status of their claims. FBCS does not support certain types of claims for non-VA care, and these claims must be processed through VistA (VA's veterans' information and electronic health record system). Overall, the high reliance on manual processes slows payment activities, introduces potential errors (e.g., lost claims and misrouting of claims), and introduces waste into the process (e.g., providers filing duplicate claims due to delays in payment and a lack of easy visibility into their status). In addition, such reliance on these manual processes reduces the timeliness and accuracy of data and obscures the true state of VHA's financial activities.*<sup>22</sup>

The Independent Assessment contained a number of provisions relating to payment processes, including a recommendation that VA “employ industry standard automated solutions to bill claims for VA medical care (revenue) and pay claims for non-VA care (payment) to increase collections, to improve payment timeliness and accuracy.”<sup>23</sup>

In October 2016, following the period of review for this audit and more than two years after the enactment of VACAA, VA issued VHA Directive 1700, *Veterans Choice Program (VCP)*. This directive “establishes policy for the implementation of VCP to ensure compliance with these laws and VA's regulations implementing the program.” The directive imposes responsibility for processing claims for care furnished through the Choice Program onto the Executive Director, Delivery Operations, and also requires

---

<sup>22</sup> CMS Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Data and Tools, Enterprise Tools: Claims Payment* (Sept. 1, 2015). p. 45.

<sup>23</sup> CMS Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Appendix I Business Processes, Summary of Recommendations: Recommendation 4* (Sept. 1, 2015). p. I-3.

“monitoring contractor related performance and testing internal controls to ensure compliance with program requirements.” The Executive Director, Revenue Operations, was tasked with “determining if patients with billable third party health insurance, other than Medicare, Medicaid, or TRICARE, have Service Connection/Special Authority eligibility to ensure accurate information is transmitted to VCP providers.”

**Program  
Administration**

VHA's OCC, under the leadership of the Deputy Under Secretary for Health for Community Care, is responsible for the administration of the PC3 and Choice Programs.

VA's PC3 program is a nationwide program for delivering care in the community which uses service contracts to provide health care for eligible veterans when the local VHA medical facilities lack available specialists, have long wait times, or are geographically inaccessible. VA entered into contracts with two Third Party Administrators (TPA), Health Net Federal Services LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest), to provide administrative services for this program. In October 2014, because of the short time frame in which the Choice Program needed to be implemented, VA decided to amend the existing PC3 contracts to add the administration of the Choice Program, including establishing provider networks, scheduling appointments, receiving medical documentation, and making payments for medical care on behalf of VA. Different provisions govern the PC3 and Choice programs within the framework of the existing contracts, and the Choice provisions of these contracts have been modified multiple times as changes and enhancements were made to the Choice Program. For the purposes of this report, we will refer to the contracts as the PC3/Choice contracts. Further, there are sub-contracting arrangements; for instance, TriWest uses Wisconsin Physician Services as a sub-contractor for all claims processing under PC3 and Choice.

**Scope of  
Payment  
Review**

Claims processing for non-VA care and the PC3 program is decentralized and performed nationwide at individual VA medical centers and consolidated payment processing centers through FBCS.<sup>24</sup> Following the enactment of Choice, VA began processing claims at a centralized location for Choice care, using FBCS, implemented via a Service Level Agreement (SLA) with VA's Financial Services Center (FSC). As will be discussed in this report, this system lacked effective internal controls and staffing was insufficient to properly handle the volume of claims. This process is the subject of this audit.

---

<sup>24</sup> Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014* (VACAA), Section 106(a)(1)(A) and (B). VACAA transferred the authority to pay for hospital care, medical services, and other health care furnished through non-VA providers from (A) the Veterans Integrated Service Networks and medical centers of the VA, to (B) the Chief Business Office (now OCC) of VHA.

Starting in March 2016, VA and the TPAs entered into a series of modifications to the PC3/Choice contracts that allowed payments on Choice claims without undergoing the established Choice payment process at FSC through FBCS; instead, the claims were paid on an aggregated basis with minimal review. This “bulk payment” claims process is the subject of the second audit described above, and the report of this audit is expected to be published in early 2018.<sup>25</sup>

In order to assess the timeliness and accuracy of payments made by VA to the TPAs which were processed via the FBCS system, OIG reviewed a sample of payment transactions from the approximately \$649 million paid to Health Net (\$69 million)<sup>26</sup> and TriWest (\$580 million) from November 1, 2014 through September 30, 2016.<sup>27</sup>

As shown in Figure 1, the majority of the dollars paid to the TPAs during this period occurred in FY 2016.

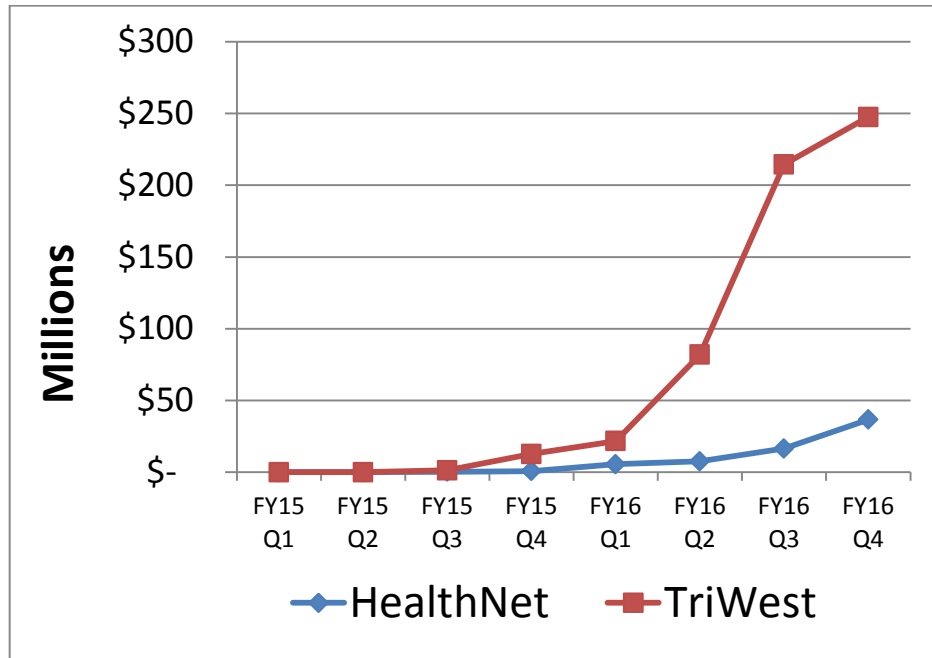
---

<sup>25</sup> In February 2017, FSC began using new medical claims adjudication software, Plexis Claims Manager, to process Choice claims.

<sup>26</sup> Health Net submitted a low volume of Choice Claims through the established Choice invoicing and payment process through FBCS during our period of review ending September 30, 2016. However, Health Net submitted a much larger volume of Choice claims through the “bulk payment” process beginning in March 2016. These claims were routed to a specific holding queue outside the scope of this audit and are the subject of a separate audit whose results will be published in a subsequent report.

<sup>27</sup> This review covered \$649 million in paid claims data for Choice medical care from November 1, 2014 through September 30, 2016 obtained from VA Central Fee Inpatient and Outpatient Fee tables. This audit did not include bulk Choice medical payments processed under the five contract modifications to the PC3/Choice contract, Choice administrative payments, or payments for Hepatitis C and other non-Department care using Choice Program funding. As mentioned, bulk payments are the subject of a separate audit and the results will be published in a subsequent report.

**Figure 1. Choice Payments Processed in FBCS  
From November 1, 2014 Through September 30, 2016**



Source: *OIG Analysis of Choice Payments to TriWest and Health Net from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

**Choice Claim  
Payment  
Process via  
FBCS**

VA reimburses the TPAs for payments the TPAs make to providers for veterans’ medical care obtained through the Choice Program. During the period of review for this audit, the TPAs’ providers were required to bill a veteran’s OHI, prior to the TPA invoicing VA for non-service connected care. After the OHI pays its portion of the care, TPAs send an invoice to VA for remaining costs, up to the Medicare rate allowed under the provisions of the Choice-specific modification, which are not covered by OHI. If the care is service-connected, or the veteran is non-service connected and does not have OHI coverage, the TPA will bill VA for the full services provided.

Under the PC3/Choice contracts, VA makes payments to the TPAs, not the providers. The TPAs are responsible for paying their providers. The rates of payment will vary depending on the type of agreement the provider has with the TPA. Under the PC3/Choice contracts, the TPAs are allowed to refer veterans to providers who are in either their PC3 or Choice networks, but a referral under either program had to be billed and paid in accordance with the contractual requirements under which the services were provided. Under the terms of the original PC3 contract, TPAs had the ability to negotiate rates with PC3 network providers, and thus some PC3 providers may be paid at rates that are below Medicare rates, with the TPAs keeping any negotiated savings. However, a provider is paid for services rendered under a Choice authorization pursuant to the terms and conditions of the contract governing



Choice, which did not allow the TPAs to retain the benefit of any negotiated discounts.

Choice providers are paid up to 100 percent of Medicare rates under the provisions of the Choice-specific modification to the PC3/Choice contracts.<sup>28</sup> If there is no established Medicare rate for the care being provided, the VA Fee Schedule<sup>29</sup> will be used. As will be discussed in this report, OIG identified instances in which VA made payments for Choice care to the TPAs for a provider that had only a PC3 agreement; the TPA then paid the provider at the PC3-negotiated discounted rate, but billed VA at the appropriate Medicare rate under the Choice-specific modification and kept the difference (failing to “pass through” the discount to VA.)

TPAs' billings are submitted to OCC electronically,<sup>30</sup> and then processed through FBCS by VA's FSC in Austin, Texas. OCC had an SLA with FSC to process Choice payments, which required FSC to process each claim received to ensure that the veteran is eligible for Choice, the care is authorized, and the claim has not been previously paid in FBCS. Following these processes, FSC batches the claim for payment.

Figure 2 illustrates the Choice payment process.

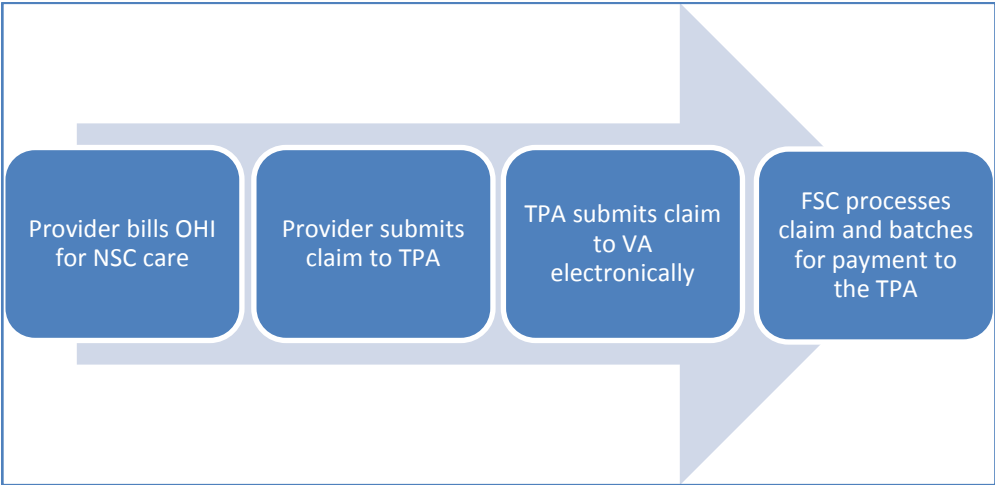
---

<sup>28</sup> The contracts allow the TPAs to exceed Medicare in highly rural areas.

<sup>29</sup> 38 CFR 17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care, (2)(i)(b) - When a given medical procedure is not payable under Medicare rules or is payable under Medicare rules but does not have established pricing at the national or local level such medical procedures will be paid based on the contracted percent of the applicable VA Medical Center Fee Schedule.

<sup>30</sup> On February 23, 2016, both TPAs signed a modification to the contract that stated, “the contractor may only submit health care claims to VA after the contractor has paid the community provider for health care services.” However, during analysis of sample items for this audit we identified a trend beginning with Choice claims that were paid by VA after March 1, 2016. In FY2016 Q3-Q4, 83 of 120 (69 percent) sample claims reviewed and paid by VA were received prior to the date TriWest paid the provider. Five of 120 (4 percent) sample claims reviewed that were paid by VA were received prior to the date Health Net paid the provider for the same period.

**Figure 2. Choice Payment Process**



*Source: OIG Analysis of Choice Payment Process Described in PC3/Choice Contracts and OCC/FSC Service Level Agreement*

## RESULTS AND RECOMMENDATIONS

### Finding 1 Twelve percent of Choice Claims Paid via FBCS Were Paid in Error

We estimated that, from November 1, 2014 through September 30, 2016, payment errors were made on approximately 224,000 of 2.0 million Choice claims (12 percent)<sup>31</sup> paid via FBCS. OCC did not design an effective internal control system to detect and prevent Choice Program payment errors. OCC improperly paid claims the TPAs submitted with errors valued at about \$39 million, as will be further explained herein.

The U.S. Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government* (Green Book) recommends that Federal agencies apply the following principles when designing internal controls for any management process.

- Create clear written policy to enforce internal controls over the payment process
- Ensure access to quality information is available for payment processing staff
- Use a well-designed information system to address the risk of payment errors
- Establish monitoring activities to ensure internal controls are working

OCC failed to apply these principles to its payment process and, as a result, overpaid TPAs about \$39 million from November 1, 2014 through September 30, 2016.

#### Payment Errors Occurred on Approximately 224,000 Claims

These errors were of the following types:

**Payment rate** - Payments made on claims that did not use the appropriate Medicare or contract adjusted rate

**OHI** - Payments made on claims that were not adjusted for the amount OHI was responsible to pay the provider

**Duplicate** - Payments for medical claims that were submitted and paid more than once

<sup>31</sup>All payment error rates presented in this report are based on projections for a randomly selected sample; see Appendix C *Statistical Sampling Methodology* for more details.

**Pass-Through** - Payments where the amount the TPAs billed and were paid was more than the TPA paid the provider

Table 2 summarizes the number of estimated payment errors and error rates broken out by these four categories.

**Table 2. Estimate of Payment Errors by Type of Error**

TPA	Payment Rate Errors	OHI Errors	Duplicate Errors	Pass-Through Errors	Total
Health Net	1,700	18,000	5,000	55,000	79,700
TriWest	39,700	79,000	25,600	0	144,300
<b>Total Errors*</b>	<b>41,400</b>	<b>97,000</b>	<b>30,600</b>	<b>55,000</b>	<b>224,000</b>
<b>Error Rates*</b>	<b>2%</b>	<b>5%</b>	<b>2%</b>	<b>3%</b>	<b>12%</b>

*Source: VA OIG Payment Error Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

*\*Tables 2 through 9 in the report contain rounded projected estimates. Some estimates were rounded at different decimal places so the columns would total for the purpose of presentation.*

**Payment Rate Errors**

We estimated that payment rate errors occurred for about 41,400 of 2.0 million (2 percent) of Choice medical claims processed from November 1, 2014 through September 30, 2016, resulting in approximately \$26.9 million in overpayments to the TPAs.

During the period of review for this audit, FSC processed Choice claims using FBCS. FSC uses the Contract Management Module to process Choice claims at “billed charges.” FSC then uses FBCS to match each claim against a VHA authorization for Choice medical care. FSC payment processing staff performed additional checks to identify claims that had been previously paid. However, according to FSC’s VHA Purchased Care Claims Supervisor, FSC employees did not use FBCS to determine if the TPAs had billed the correct Medicare contract rates because FBCS did not have the capability to do this for Choice claims. According to OCC’s Director of Claims Adjudication and Reimbursement, OCC relied on the TPAs to ensure that Choice claims were billed at the correct Medicare rate and did not verify that the TPAs billed at the correct rate prior to paying claims. During the time FSC was processing claims through FBCS, FSC was instructed, by OCC’s Director of Claims Adjudication and Reimbursement to pay the amount the TPA billed on the claim or what has been referred to as “billed charges.” He further stated that it was the TPAs’ responsibility to adjudicate claims for correct charges prior to billing OCC.

It appears that while VA negotiated or established rates with providers as required by VACAA, it failed to design or implement procedures that would

enable it to determine whether providers were billing at the correct rate and instead relied solely upon the TPAs; similarly, VA did not design or implement any audit or control procedures that would have enabled it to determine if the TPAs were submitting invoices with the correct rates during our period of review.

To determine whether claims were paid at the correct Medicare rate, we used a contractor which specializes in processing medical claim payments to review each claim in our audit sample for pricing accuracy. These examples of Payment Rate Errors were identified in this review:

**Example 1**

TriWest billed \$977.00 for a Total Hip Arthroplasty procedure provided through the Choice Program. TriWest billed OCC using Current Procedural Terminology (CPT) code 27130 with an 81 modifier (Assistant at Surgery) for treatment provided on May 11, 2015. The contract medical claim processor determined that \$223.02 was the correct Medicare rate for CPT code 27130 with an 81 modifier. OCC overpaid \$753.98 for this service.

**Example 2**

TriWest billed \$3,797.00 for a Mohs Micrographic Surgery and Adjacent Tissue Transfer procedure provided through the Choice Program. TriWest billed OCC using CPT codes 17311 and 14061 for treatment provided on November 2, 2015. The contract medical claim processor determined that \$1,256.88 was the correct Medicare rate for this claim. OCC overpaid \$2,540.12 for these services.

Table 3 summarizes the estimated number of payment rate errors from November 1, 2014 through September 30, 2016.

**Table 3. Estimate of Payment Rate Errors**

TPA	Payment Rate Errors	Claims Paid	Rate of Error
Health Net	1,700	400,000	0%
TriWest	39,700	1,600,000	2%
<b>Total</b>	<b>41,400</b>	<b>2,000,000</b>	<b>2%</b>

*Source: VA OIG Payment Error Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

After rounding, we estimated an overall payment rate of error of zero percent for Health Net. During our period of review, we observed that Health Net performed daily pre-payment audits to ensure claims were keyed and processed accurately, and weekly post-payment audits to ensure claims were processed and adjudicated accurately and completely, which may explain Health Net's lower rate of error.

OHI Payment  
Errors

We estimated that OHI errors occurred for about 97,000 of 2.0 million (5 percent) of Choice medical claims processed from November 1, 2014 through September 30, 2016, resulting in approximately \$6.5 million in overpayments to the TPAs.

During our period of review, VACAA required veterans' OHI to be the primary payer when they received non-service connected treatment through Choice.<sup>32</sup> Section 101(e)(3)(B)(ii) states, "the Secretary shall be responsible for promptly paying only the amount that is not covered by such health-care plan."

The PC3/Choice contracts require the TPAs to collect and document veterans' OHI information prior to scheduling an appointment with a provider and to ensure a veteran's OHI is billed when receiving treatment that is non-service connected. TPA guidance to providers states the TPAs will notify the provider if VA will be a secondary payer and the provider will be responsible for seeking reimbursement from the veteran's health care plan. The TPAs were further required to ensure that providers bill the veteran's OHI as the primary payer before submitting a claim with the accompanying Explanation of Benefits (EOB) to the TPA. The TPA then is allowed to bill VA for any remaining costs up to the amount allowable under the PC3/Choice contracts.<sup>33</sup> VA, however, does not have effective procedures in place to ensure that the TPAs comply with these contractual obligations.

According to a senior OCC official, during the initial implementation of Choice, the TPAs and OCC could not reach agreement on the costs associated with submitting EOB information electronically with Choice health-care claims. This resulted in no process being developed to submit EOB/OHI information electronically to OCC when the Choice payment process was established and implemented.<sup>34</sup>

---

<sup>32</sup> Public Law 113-146 (August 7, 2014), Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Section 101(e).

<sup>33</sup> Although the PC3/Choice contracts imposed this burden on the providers and TPAs, VA is authorized by statute to seek reimbursement from third-party health insurers for the cost of non-service connected care for veterans treated at VA facilities under the Medical Care Collections Fund. In April 2017, VACAA was amended to make VA the primary payer for medical care relating to non-service connected medical needs and recovery of costs from third parties, including OHI. This amendment removed responsibility for recovering payments from OHI from providers and the TPAs and imposed it on VA.

<sup>34</sup> VA attempted to continue to negotiate the requirement for TPAs to submit EOB information in future modifications signed by Health Net and TriWest on September 17, 2015 (modifications 9 and 10) However, both negotiations were unsuccessful and no agreement on price could be reached with either TPA, so the requirement was removed from the modifications without resolution.

According to FSC and OCC officials, no process was in place to determine whether OHI had first-party responsibility prior to FSC processing payment. FSC was not receiving and reviewing EOB information as a part of the payment process. As indicated, FSC's guidance from OCC has been to pay "billed charges." OCC management acknowledged that it did not have procedures in place to address the requirements associated with making OHI the primary payer for non-service connected care.

We identified OHI-related payment errors in our sample by reviewing VA medical records, VA payment data, Electronic Data Interchange claims received, and TPA remittance advice. These errors occurred when VA was paying claims submitted by the TPAs for veterans with OHI whose care was not service-connected and the services had not been billed to or paid by the veteran's OHI as the primary payer.

To confirm the existence of the OHI errors we found in our sample, OCC's Revenue Operations Division staff reviewed each identified OHI error to determine if it was billable. First, OCC Revenue Operations staff verified whether the OHI coverage was active at the time the veteran received treatment. Next, an OCC Revenue Operations Utilization Review Nurse reviewed the record to determine if the treatment was service-connected or otherwise provided under special authority, and if not, confirmed the care was non-service connected and thus the responsibility of OHI as primary payer, with OCC having secondary payer responsibility.

These payments are examples of OHI errors in which the provider should have billed the veteran's OHI prior to submitting a claim to the TPA:

**Example 3**

Health Net billed \$160.34 for a claim for a therapeutic procedure provided through the Choice Program. We determined the treatment was not related to a service-connected condition or special authority and the veteran possessed billable OHI. OCC paid \$160.34, the full Medicare rate, for the therapeutic procedure. In addition, Health Net reimbursed the provider \$160.34 without any evidence of an offset for OHI.

**Example 4**

TriWest billed \$420.75 for a claim for a surgical procedure provided through the Choice Program. We determined the procedure was not related to a service-connected condition or special authority and the veteran possessed billable OHI. OCC paid \$420.75, the full Medicare rate, for the surgical procedure. In addition, TriWest reimbursed the provider \$420.75 without any evidence of an offset for OHI.

We estimated that OCC paid \$17.5 million on approximately 97,000 claims when veterans' OHI should have been billed as the primary payer. We estimated \$6.5 million of the \$17.5 million paid by VA would have been recovered from veterans' OHI, based on VA's Medical Care Collection

Fund's (MCCF) FY 2016 third-party collections to billing percentage of 37.5 percent.<sup>35</sup> VA's MCCF third-party collections to billing percentage is what VA collects for each dollar billed to third-party insurance for medical services when it provides care for veterans directly or indirectly through community care providers and must pursue collection from the insurers; it thus provides a reasonable benchmark for the amount VA could expect to recover if it sought payment from OHI carriers for services provided under Choice.

Table 4 summarizes the estimated number of OHI payment errors made by OCC from November 1, 2014 through September 30, 2016.

**Table 4. Estimate of OHI Payment Errors**

TPA	OHI Errors	Claims Paid	Rate of Error
Health Net	18,000	400,000	5%
TriWest	79,000	1,600,000	5%
<b>Total</b>	<b>97,000</b>	<b>2,000,000</b>	<b>5%</b>

*Source: VA OIG Payment Error Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

**Duplicate Payment Errors**

We estimated that approximately 30,600 of the 2.0 million (2 percent) of Choice medical claims processed from November 1, 2014 through September 30, 2016 were duplicate claims that should not have been paid. This resulted in approximately \$3.8 million in overpayments to the TPAs. To identify duplicate payments, key elements from our sample of paid claims were compared against all claims paid in our audit universe. These key claim elements included: CPT codes and modifiers, treatment dates, Social Security numbers, and National Provider Identifier numbers.

These are examples of duplicate payments found in our audit sample:

**Example 5**

TriWest billed \$285.96 for an outpatient eye procedure provided under the Choice Program. The eye procedure was billed under CPT code 66821 (Incision Procedure on Lens of Eye) with an LT (left) modifier for treatment, which occurred on February 12, 2015. VA received the claim for the procedure on April 8, 2015 and paid it on May 4, 2015. We compared this claim against paid non-VA care claims in our audit universe to determine if it was paid more than once. We identified a second claim in which OCC reimbursed the

<sup>35</sup> The actual amount cannot be determined without evidence of what would have been paid by the veterans' OHI as the primary payer for each claim.



TPA \$285.96 for a claim with a matching CPT code and LT modifier for the same veteran and same treatment date. The second claim was received by VA on May 5, 2015 and paid on June 1, 2015. We determined this payment to be a duplicate.

Example 6

Health Net billed \$40.76 for chiropractic care provided under the Choice Program. The December 17, 2014 chiropractic treatment was billed under CPT code 98940 (Chiropractic Manipulative Treatment) for \$27.39 and CPT code G0283 (Electrical Stimulation) for \$13.37. VA received a claim for this treatment on February 28, 2015 and it was paid on March 25, 2015. We compared this claim against paid non-VA care claims in our audit universe to determine if it was paid more than once. We identified a second claim in which OCC reimbursed the TPA \$27.39 for CPT code 98940 with an AT (Active Treatment) modifier for the same veteran and provider performed on the same date. The second claim was also received by VA on February 28, 2015 and paid on March 25, 2015. We determined this payment to be a duplicate.

Table 5 summarizes the estimated number of duplicate payment errors from November 1, 2014 through September 30, 2016.

**Table 5. Estimate of Duplicate Payment Errors**

TPA	Duplicate Errors	Claims Paid	Rate of Error
Health Net	5,000	400,000	1%
TriWest	25,600	1,600,000	2%
<b>Total</b>	<b>30,600</b>	<b>2,000,000</b>	<b>2%</b>

*Source: VA OIG Payment Error Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

The TPAs did not have sufficient processes for ensuring that duplicate invoices were not sent to VA and that VA did not pay them, and VA's processes for identifying and avoiding payment of duplicate claims were insufficient.

Pass-Through Errors

We estimated that OCC reimbursed one TPA more than the TPA paid providers for about 55,000 of 2.0 million (3 percent) of Choice medical claims processed from November 1, 2014 through September 30, 2016. These pass-through errors resulted in approximately \$1.8 million in overpayments to one TPA (Health Net).

Under the PC3 contracts, no language prevented TPAs from negotiating reimbursement rates with their providers discounted below Medicare rates,<sup>36</sup> and prior to the PC3 contract being modified to include Choice, TPAs were able to keep the difference between the amount paid by OCC for medical services and the amount they paid their providers as defined by negotiated PC3 network provider agreements. The fee paid to the TPAs for processing PC3 authorizations varied by region but ranged from \$45 to \$123. When VA modified the PC3 contracts in October 2014 to include Choice, this language was added to the contract:

*The contractor shall not negotiate discounts off the Medicare rate with providers that sign VACAA-specific agreements, and the full rate due must be a full pass-through in accordance with this CLIN [Contract Line Item Number].*

This provision removed the TPA's ability to retain the price difference between what OCC paid the TPA for medical services and the amount the TPA reimbursed providers under the Choice portion of the contract. VA and the TPAs, however, negotiated a fee that ranged from about \$295 to \$300 to administer each Choice authorization, which represented a significant increase over the PC3 fee.

However, TPAs interpreted the contract as allowing them to send Choice patients to their PC3 network providers<sup>37</sup> who received reimbursement below Medicare rates, while billing VA at 100 percent of the Medicare rate. VA and the TPAs modified the original pass-through language on September 17, 2015, as indicated below (italics added), to clarify the definition of a pass-through payment after this practice came to their attention.<sup>38</sup>

*“The contractor shall not negotiate discounts off the Medicare rate with providers that sign VACAA-specific agreements. The full rate due, as agreed upon with the provider in the provider agreement must be a full pass-through in accordance with this CLIN, up to 100% of Medicare.”*

---

<sup>36</sup> According to one TPA, the ability to negotiate discounts and keep the savings was considered to be part of the revenue to be generated for the TPA, given the low fee to be paid for each authorization.

<sup>37</sup> The Choice contract provisions required that TPAs pass through any discounts. We considered a pass-through error to be when OCC reimbursed the TPA more than the TPA paid the provider.

<sup>38</sup> The Price Negotiation Memorandum noted that VA's Office of General Counsel advised that the applicable language was ambiguous and, therefore, OCC could not seek to recover amounts the TPAs retained as a result of not passing through any PC3-negotiated rates below the full Medicare rate paid under Choice.

In light of the Office of General Counsel's interpretation, as reflected in the Price Negotiation Memorandum and the subsequent modification, we did not undertake to review the amounts retained by the TPAs by failing to pass through negotiated PC3 discounts for Choice authorizations prior to that modification. Instead, we focused on payments made after the contract was modified in September 2015. We considered a pass-through error to be when OCC reimbursed the TPA more than the TPA paid the provider. To identify pass-through errors, we collected copies of the remittance advice for each of the claims in our sample from the TPAs to determine what the TPA paid the provider. We then compared the amounts TPAs paid their providers to the amounts OCC paid the TPAs and determined the payments were in error when the TPAs paid the providers less than they billed VA for the same treatment.

We estimated there were 55,000 pass-through payment errors, when OCC reimbursed Health Net more than they paid their providers. We did not identify any pass-through payment errors in our sample review for TriWest following the 2015 modification.

These are examples of pass-through errors in which Health Net billed and OCC paid Health Net more than Health Net paid its provider.

**Example 7**

Health Net billed and OCC paid \$146.30 for inpatient hospital services provided through the Choice Program. Health Net billed OCC using CPT code 99232 (subsequent hospital care) for treatment provided on June 4 and 5, 2015. We reviewed the provider's remittance advice and determined Health Net paid the provider \$124.36 for this service but did not pass the discounted rate through to OCC. As a result, OCC overpaid the claim by \$21.94.

**Example 8**

Health Net billed and OCC paid \$88.26 for contact lens evaluation provided through the Choice Program. Health Net billed OCC using CPT code 92310 (lens fitting) for treatment that was provided on August 27, 2015. We reviewed the provider's remittance advice and determined Health Net paid the provider \$46.63 for this service but did not pass the discounted rate through to OCC. As a result, OCC overpaid the claim by \$41.63.

Table 6 summarizes the estimated number of pass-through payment errors.

**Table 6. Estimated Pass-Through Payment Errors**

TPA	Pass-Through Errors	Claims Paid	Rate of Error
Health Net	55,000	400,000	14%
TriWest	0	1,600,000	0%
<b>Total</b>	<b>55,000</b>	<b>2,000,000</b>	<b>3%</b>

Source: VA OIG Payment Error Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016

**VA Failed To Meet Statutory and Regulatory Requirements Governing Claims and Payment Processing**

VACAA requires VA to implement an “efficient nationwide system for processing and paying bills or claims for authorized care and services furnished to eligible veterans under this section,”<sup>39</sup> and requires that the Secretary “ensure that such system meets such goals for accuracy of payment as the Secretary shall specify for purposes of this section.”<sup>40</sup> The regulations prescribed by VACAA to implement the Choice Program further require that VA assume the responsibility of overseeing and implementing a claims processing system that “will provide accurate, timely payments for claims received...”<sup>41</sup> VA’s failure to design and implement an appropriate claims and payment processing system has led to an environment in which the errors described in this report were able to occur.

**OCC’s Internal Control Weaknesses Contributed to Payment Errors**

The Green Book defines internal control standards for Federal Government agencies through five components consisting of 17 key principles necessary to produce an effective internal control system. During our review, we found several internal control weaknesses in the Choice payment process, which contributed to the errors discussed in this report. We concluded that OCC did not appropriately design, implement, monitor, and enforce an effective internal control system for the Choice payment process. We determined that OCC did not appropriately follow these internal control principles:

- Create clear written policy for the payment of claims
- Ensure access to quality information is available for payment processing staff
- Use a well-designed information system to address the risk of overpaying medical claims
- Establish monitoring activities to ensure internal controls are working

<sup>39</sup> Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014* (VACAA), section 101(k)(1).

<sup>40</sup> *Ibid*, Section 101(k)((4)(a).

<sup>41</sup> 38 CFR 17.1540 *Claims processing system*.

**OCC Did Not Establish Clear Written Policy for Choice Payment Process**

Starting on October 30, 2014, OCC modified the PC3 contracts with TriWest and Health Net to implement the Choice Program in order to meet the 90-day implementation requirement imposed in VACAA. According to OCC officials, OCC designed the initial Choice payment process using existing non-VA care claims processing procedures. OCC began making payments for Choice claims in March 2015.

In June 2015, Choice claim processing was transferred to FSC through the use of an SLA between OCC and FSC. OCC field representatives met with FSC staff to provide informal training for Choice payment processing prior to work being formally transferred in February 2015.

According to FSC officials, no written or formal procedures existed to ensure that accurate Medicare reimbursement rates were applied by the TPAs when processing Choice claims. Instead, OCC instructed FSC to pay billed charges received on Choice claims even though no procedures or controls were in place to determine whether the Medicare rate billed by the TPAs was accurate.<sup>42</sup>

VACAA<sup>43</sup> transferred to OCC responsibility for processing all payments for medical care received from non-VA providers. OCC needs to develop appropriate policies and procedures governing the processing of invoices for reimbursement, such as ensuring that payment processing staff have the ability to determine if the charges billed on Choice claims are correct prior to issuing payment.

We address the need for written payment policies to guide the Choice payment process in Recommendation 1.

**OCC Did Not Ensure Quality Information Was Available to Payment Staff**

The Green Book recommends that management use quality information to achieve an entity's objective. Effective payment procedures require that relevant data from reliable sources be used. OCC did not design payment procedures that provided payment processing staff with all the information necessary to ensure that TPAs were billing and being paid accurately. Several of the error types we discussed earlier in our report could have been avoided if key information had been available to payment staff at the time of payment processing. For example, the estimated 55,000 pass-through errors

---

<sup>42</sup> According to OCC officials, during the implementation of Choice, OCC did not provide a detailed policy and procedure manual to guide the TPAs in adjudicating and processing claims; both TPAs cited the absence of such a manual as the cause of a substantial amount of confusion and lack of clarity, leading to payment delays and payment errors. Both TPAs cited, by contrast, the lengthy and detailed policy manual provided by the Department of Defense for processing claims for medical services provided under its TriCare program.

<sup>43</sup> Public Law 113-146 (August 7, 2014), *Veterans Access, Choice, and Accountability Act of 2014* (VACAA), Section 106(a)(1)(A) and (B).

discussed earlier could have been prevented had the payment staff received remittance advice from the TPA along with the submitted claims.

A remittance advice is used to document how the claim was processed and how much the TPA will pay the provider. This documentation is necessary to ensure the TPAs billed in accordance with the PC3/Choice contracts and were not reimbursed more than they paid their providers. The PC3/Choice contracts do not require the TPAs to submit remittance advice showing how much they paid their providers. OCC needs to receive remittance advice documentation to ensure OCC does not pay more than it is contractually obligated to pay for medical services. In addition, OCC needs to establish internal controls and procedures to use remittance advice so payment processing staff are able to process Choice claim payments in accordance with contract terms.

We address the need for payment staff to have accurate information regarding TPA remittance advice data in Recommendation 2.

**OCC Did Not Have Controls To Ensure OHI Was Billed Appropriately**

During the period of review for this audit, the PC3/Choice contracts required the TPAs to inform providers that they must bill the veterans' OHI as the primary payer for care that is not service-connected and then submit to the TPA the remaining amount (i.e., the difference between the amount paid by OHI and the Medicare reimbursement rate) for reimbursement.

When a provider bills a veteran's OHI, the provider should receive an EOB along with the payment. These EOBs will explain what medical treatments and/or services were allowed by veterans' OHI and how much was paid. The TPA is only allowed to bill VA the remaining amount owed at the Medicare or contract adjusted rate that was not covered by the veteran's OHI. The TPA will then bill VA as the secondary payer for the same amount the TPA reimbursed their providers after first-party OHI has made payment.

OCC did not have internal controls to ensure that claims for payment of non-service connected care under Choice claims with OHI were identified and paid properly. OCC failed to establish procedures to route EOB information received from TPAs to payment processing staff and subsequently never designed payment processing procedures to ensure that Choice claims with OHI were paid in accordance with contract terms.

We address the need for processing staff to have access to documentation from the TPAs verifying amounts paid to providers to ensure pass-through payments are accurate in Recommendation 3.

**OCC Did Not Have an Information System That Could Prevent Overpayments**

FBCS was designed to improve payment accuracy and efficiency of payments for non-VA care, as well as to enforce payment rules established in CFR sections 17.55 and 17.56 for pre-authorized inpatient and outpatient non-VA care.

GAO recommends that management design appropriate business process controls that are incorporated directly into computer applications, such as FBCS, to ensure transaction processing is accurate. The FBCS manual states that FBCS has the functionality to perform automatic repricing for all claims that meet repricing business rules; however, this functionality does not include the ability to compare rates charged for medical services in a claim against contracted rates.

Furthermore, according to OCC officials, FBCS did not have the capability to accommodate the new payment requirements set forth in the PC3/Choice contracts during the 90-day Choice implementation period.<sup>44</sup> The Choice Program payments are based upon Medicare rates, similar to other non-VA care programs; however, Choice payments have additional requirements. Under the terms of the PC3/Choice contract, the Medicare rate will be adjusted if the payment is for:

- Treatment provided in a highly rural area
- Non-service connected care, which is subject to first-party OHI reimbursement
- Treatment provided at a discount by non-VACAA providers

However, these additional variables were not incorporated into the business rules used to process claims and the system was used “as is” without modifying the business rules needed to enforce the terms of the contract. We address the weaknesses of the FBCS payment processing system in Recommendation 4.

**OCC Did Not Monitor the Payment Process**

OCC must monitor the payment process to ensure the controls in place are effective. OCC was not adjudicating the pricing on Choice claims before they were paid. When we questioned OCC's Director of Claims Adjudication and Reimbursement, he stated that OCC relied on the TPAs to ensure Choice claims were billed at the correct Medicare rate and did not verify that the TPAs billed at the correct rate prior to paying claims. He also stated that OCC would only pay “billed charges” when processing Choice claims and there was no determination of whether the TPA billed the correct Medicare rate. He further stated that it was the TPAs' responsibility to

---

<sup>44</sup> In the “Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care”, October 30, 2015, VA stated that in designing and implementing the new VCP, it would pursue a claims system that employs best practices, standardized business rules, and auto adjudication.

adjudicate claims for correct charges prior to billing OCC. This failure to adjudicate claims pricing prior to payment resulted in payment errors, including overpayments by VA.

The accuracy of the payment process can also be monitored via periodic post-payment recovery audits. OCC employs a contractor to perform post-payment audits and collect overpayments from providers in other non-VA care programs but, as of October 2017, no contractor has been hired to perform a post-payment recovery audit of Choice claims.<sup>45</sup> Similar controls are needed for the Choice Program payment process to ensure payment accuracy.

In November 2015, VA's Office of Business Oversight, Management Quality Assurance Service, recommended that OCC develop a process to review Choice payments for correct billing prior to payment. OCC responded to the recommendation by indicating that it would review existing guidance for the appropriate changes which address reviewing payments for correct billing prior to payment and that it would initiate follow-up audits to ensure correct billing and proper payments—with a planned completion date of September 30, 2016. However, as of August 2017, OCC had not completed a follow-up audit of Choice payments paid via FBCS for correct billing and proper payments.

The Green Book cites management's responsibility to complete and document corrective actions to remedy internal control deficiencies on a timely basis. Depending on the nature of the deficiency, either the oversight body or management oversees the prompt remediation of deficiencies. OCC's Department of Audits and Internal Controls (DAIC) group is responsible for performing oversight of OCC business policies, plans, and procedures, including Choice. DAIC is responsible for performing post-payment audits of Choice claims processing and payment accuracy. According to the Acting Chief, at the time of our review, DAIC was in the process of conducting a post-payment audit of FBCS claims, which should have been completed in the 4<sup>th</sup> quarter of FY 2017.

We address the weaknesses of the OCC's lack of monitoring in Recommendation 5.

**Weak Controls  
Resulted in  
Overpayments  
of \$39 Million**

We estimated OCC made approximately 224,000 payment errors from November 1, 2014 through September 30, 2016. These payment errors resulted in an estimated overpayment of about \$39 million during our period of review. Table 7 summarizes the monetary value of estimated overpayments by error type.

---

<sup>45</sup> The Deputy Director of VHA's OCC stated that OCC is in the process of hiring a vendor to perform post-payment recovery audits of Choice payments.



**Table 7. Estimated Monetary Impact of Payment Errors**

<b>Error Type</b>	<b>Health Net</b>	<b>TriWest</b>	<b>Total</b>
Duplicate	\$0.7 million	\$3.1 million	\$3.8 million
OHI*	\$1.0 million	\$5.5 million	\$6.5 million
Pass-Through	\$1.8 million	N/A	\$1.8 million
Payment Rate	\$0.3 million	\$26.6 million	\$26.9 million
<b>Total</b>	<b>\$3.8 million</b>	<b>\$35.2 million</b>	<b>\$39 million</b>

*Source: VA OIG estimated overpayments based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

*\* We estimated \$6.5 million of the \$17.5 million paid by VA would have been paid by veterans' OHI based on VA's MCCF FY 2016 third-party collections to billing percentage of 37.5 percent.*

The Improper Payments and Recovery Act of 2010, Public Law 111-204, defines improper payments as any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The definition of improper payments includes any payment to an ineligible recipient or for an ineligible good or service. We determined that the estimated \$39 million of overpayment identified in our report were improper payments made to the TPAs. We recommended that VA continue to work with relevant Government authorities to review and determine an appropriate process for reimbursement.

**Conclusion**

OCC failed to comply with VACAA regulations when it established payment processing systems that did not function efficiently and did not have proper controls to ensure payment accuracy. TPAs improperly billed OCC, and OCC made an estimated 224,000 payment errors when paying the TPAs because OCC did not have in place an effective internal control system for the Choice payment process to ensure Choice payment accuracy.

OCC needs to clearly document its payment processes, ensure payment staff have access to accurate quality information, update payment processing software to enforce Choice contract payment criteria, and implement post-payment audits to confirm internal controls are achieving desired results. Until OCC implements effective internal controls over Choice payments, OCC will continue to overpay TPAs for medical care. In addition, OCC needs to have effective performance standards in place to hold providers and TPAs accountable for complying with their contractual obligations.

## Recommendations

1. We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators, as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.
2. We recommended the Executive in Charge, Veterans Health Administration, ensure payment processing staff have access to documentation from the Third Party Administrators verifying amounts paid to providers to ensure the Third Party Administrators are not billing VA more than they paid the provider for medical claims.
3. We recommended the Executive in Charge, Veterans Health Administration, ensure Veterans Health Administration payment staff have access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.
4. We recommended the Executive in Charge, Veterans Health Administration, ensure the new payment processing systems used for processing medical claims from Third Party Administrators have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.
5. We recommended the Executive in Charge, Veterans Health Administration, ensure VA performs post-payment audits on a periodic basis to determine if payments made to Third Party Administrators for medical care are accurate.
6. We recommended the Executive in Charge, Veterans Health Administration, ensure that Office of Community Care staff and members of VA's Office of General Counsel continue to work collaboratively with relevant Government authorities to review and determine an appropriate process for reimbursement.

### Agency Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with our findings and agreed that a full review of payments made under the Veterans Choice Program and recovery of all identified overpayments is essential. The Executive in Charge concurred with Recommendations 1, 3, 5, and 6. The Executive in Charge concurred in principle with Recommendations 2 and 4.

To address Recommendation 1, the Executive in Charge reported that a Contractor Claims Processing Standard Operating Procedure (SOP) and an

OCC Claims Processing SOP are being developed to clearly outline procedures and expectations for VA employees and TPAs.

To address Recommendation 2, the Executive in Charge reported VHA will make improvements during the implementation of the Community Care Network (CCN) by requiring that TPAs submit documentation indicating the amount paid to providers.

To address Recommendation 3, the Executive in Charge reported that the CCN contract will require that claims processing staff have access to Veterans' health insurance information to accurately assess coordination of benefits requirements and these processes for VA employees and TPAs will be clearly outlined in the SOP being created.

To address Recommendation 4, the Executive in Charge reported that VHA ended the use of the FBCS system to process Choice claims and replaced it with the Plexis Claims Manager by the FSC. She also reported that as of July 2017, OCC uses its Program Integrity Tool, an electronic tool with advanced data analytic capabilities, to identify duplicate payments prior to payment for Choice payments. The FSC also performs a separate duplicate payment analysis prior to processing claims in the Plexis Claims Manager. She reported VHA will use a commercial off-the-shelf reimbursement system that includes Fraud, Waste and Abuse tools, data analytics, and financial measures to process payments to CCN providers.

To address Recommendation 5, the Executive in Charge reported that the OCC and the FSC have performed a number of post-payment reviews to assess payment accuracy beginning in early 2017 when VHA OCC's internal auditors reported duplicate payments to TPAs were an area of concern to senior management. The CCN contract language will require that TPAs hire an independent third-party auditor to ensure payment accuracy, and incentives/disincentives have been incorporated into the CCN contract language based on payment accuracy.

To address Recommendation 6, the Executive in Charge reported that VHA OCC will continue to work collaboratively with the VA Office of General Counsel, the OIG, and all relevant Government authorities to pursue an appropriate reimbursement process for identified Choice overpayments.

**OIG Response**

The Executive in Charge for the Office of the Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all actions are completed in both the existing Choice Program and the future CCN. As of December 2017, VHA has not provided us evidence necessary to close Recommendations 1 through 6. Once evidence is received and examined, we will determine if VHA's actions are sufficient to close the recommendations.

**Finding 2      OCC Did Not Pay TPAs in Accordance With the Prompt Payment Act**

We estimated that OCC payments to TPAs for approximately 1.0 million of 2 million claims (50 percent) were made in excess of the 30-day Prompt Payment Standard from November 1, 2014 through September 30, 2016. OCC's payments averaged 37 days to Health Net and 36 days to TriWest. These payment delays occurred because OCC did not accurately estimate the amount of staff necessary to process Choice claims through its SLA with the FSC. This resulted in \$164,956 in interest payments for late reimbursements to TPAs. In addition, although VACAA requires VA to meet the timeliness standards of the Prompt Payment Act in paying the TPAs, the PC3/Choice contracts do not specify a timeliness standard applicable to the TPAs for their payments to providers.<sup>46</sup>

**OCC Did Not Comply With the Prompt Payment Act for 50 Percent of Payments to TPAs**

The Prompt Payment Act requires VA to pay contractors, which would include TPAs under the PC3/Choice contracts, within 30 days of receipt of a proper claim from the TPA. We calculated payment timeliness by comparing the date VA received TPA claims to the date VA paid the claims. Table 8 summarizes OCC's payments to each TPA by payment timeliness category.

**Table 8. Projected Payment Timeliness - OCC Payments to TPAs**

Payment Category	Health Net	TriWest	Total	Percentage
≤ 30 days	200,000	800,000	1,000,000	50%
> 30 days	200,000	800,000	1,000,000	50%
<b>Totals*</b>	400,000	1,600,000	2,000,000	100%

*Source: VA OIG Payment Timeliness Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

We believe these late payments are at least partially attributable to the fact that OCC did not accurately estimate an appropriate level of claims processing staff to meet Choice demand in its SLA with the FSC.

<sup>46</sup> Public Law 113-146 (August 7, 2014), Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Section 105(b)(1) and (2). VACAA requires VA to establish a claims processing system that complies with all requirements of the Prompt Payment Act, 5 CFR part 1315 – Prompt Payment.

**Health Net and TriWest Payments to Providers Also Exceeded 30 Days**

We estimated Health Net took 47 days on average to pay its providers from November 1, 2014 through September 30, 2016. TriWest averaged 39 days to pay its providers for the same period. We compared the date a Choice claim was received by the TPA to the date the claim was paid to determine how long TPAs took to pay the provider. Although TPA payments to providers exceeded 30 days, we did not have specific standards to measure payment timeliness because the PC3/Choice contract did not include a payment timeliness standard applicable to payment by the TPAs to their providers. Therefore, OCC did not have a contractual standard to enforce payment timeliness standards on Choice payments by the TPAs to providers. Table 9 summarizes Health Net and TriWest payment timeliness to their providers.

**Table 9. Projected Payment Timeliness - TPAs to Providers**

Payment Category	Health Net	TriWest	Total	Percentage
≤ 30 days	150,000	650,000	800,000	40%
> 30 days	250,000	950,000	1,200,000	60%
<b>Totals</b>	400,000	1,600,000	2,000,000	100%

*Source: VA OIG Payment Timeliness Projections for TPA payments to providers based on data obtained from Health Net and TriWest for each of our sample times for the period of November 1, 2014 through September 30, 2016*

**OCC Did Not Accurately Estimate Claims Processing Staffing To Meet Choice Demand**

OCC did not effectively estimate the number of processing staff that FSC would need to process Choice claims as program use increased. Under the FY 2016 SLA, FSC was required to provide up to 75 staff members to process Choice claims in FBCS through March 2016. According to FSC officials, their actual average daily staffing levels had risen to 303 staff by March 2016, a roughly 300 percent increase over their estimated needs to meet OCC's claims processing goals in the FY 2016 SLA signed in December 2015. According to FSC internal claims processing reporting, the "on-time" percentage for processing Choice claims within 30 days went from 99.8 percent in September 2015 to 8.3 percent in December 2015.

FSC Supervisory staff stated that, starting in October 2015, FSC began receiving large volumes of Choice claim transmissions from the TPAs, which staff struggled to process within 30 days. In June 2016, Health Net informed OCC and FSC that it had accumulated a backlog of 400,000 claims, which was more than the existing claims inventory at FSC at that time. VA requested that Health Net submit 10,000 to 16,000 claims per day until the backlog had been resolved.

FSC claims processing officials stated that OCC did not provide any forecasts that projected the rapid rise in claim volume. According to an FSC

supervisor, the end-of-month Choice claim inventory increased from approximately 64,000 to 331,000 claims, or 400 percent, and aged claims over 30 days increased from 1,254 to 176,000 claims, or 13,900 percent, from October 2015 through June 2016. In an attempt to catch up with the rising volume of Choice claims, average processing staffing levels increased from 45 daily staff in October 2015 to 284 in June 2016. In the FY 2016 SLA agreement between OCC and FSC, the maximum projected need for payment processing staff was 75, far less than what was necessary to keep up with rapidly rising claim submissions.

We address OCC's need to ensure it has the capacity to process projected claims volumes in Recommendation 7.

**OCC's  
PC3/Choice  
Contracts  
Lacked  
Performance  
Standards for  
TPA Payment  
Timeliness**

During our review of OCC's contracts with the TPAs, we found the PC3/Choice contracts did not contain provisions establishing the time within which the TPAs must pay providers for health care services provided under the Choice Program. Health Net's payments to providers averaged 47 days and TriWest's averaged 39 days. VACAA Section 105 conveys the "sense of Congress" that VA is to comply with Federal laws, regulations, and rulings requiring prompt payments for health care pursuant to contracts entered into with non-VA providers. In addition, the Act requires that the claims processing system to be established by VA comply with prompt payment laws and regulations. Therefore, we concluded that the intent of VACAA was to ensure health care providers are paid in accordance with prompt payment principles,<sup>47</sup> which require payment within 30 days of the receipt of an invoice.

During our review of OCC's PC3/Choice contracts with the TPAs, we found a clause stating that the Government will make payments in accordance with prompt payment regulations.<sup>48</sup> However, we found that the PC3/Choice contracts do not specify that any timeliness standard applies to TPA payments to providers for health-care services offered under the Choice Program. It is our opinion that the intent of VACAA Section 105 is to ensure timely payments to health care providers. Therefore, we believe the PC3/Choice contracts should have included a provision requiring the TPAs to make timely payments to the health care providers.

We address VHA's need to ensure TPAs comply with VACAA payment timeliness standards in Recommendation 8.

---

<sup>47</sup> 5 CFR Part 1315 – Prompt Payment.

<sup>48</sup> 5 CFR Part 1315 – Prompt Payment and 31 United States Code 3903 – Prompt Payment.

**Conclusion**

OCC did not implement an efficient claims processing system for Choice claims, nor did it adequately estimate staffing levels in the SLA with the FSC. Until resources can be allocated ahead of time to manage the Choice claims volume demand, OCC will continue to face late payments and penalty interest charges. Moreover, unless OCC adds a standard for Choice payment timeliness to the PC3/Choice contracts for Health Net and TriWest, it will not have a control in place to enforce timely payments to Choice providers.

**Recommendations**

7. We recommended the Executive in Charge, Veterans Health Administration, ensure the Veterans Health Administration has sufficient claims processing capacity to timely meet and process expected claim volume from the Third Party Administrators.
8. We recommended the Executive in Charge, Veterans Health Administration, ensure that future contracts with Third Party Administrators contain payment timeliness standards for the processing of claims from health care providers.

**Agency Comments**

The Executive in Charge, Office of the Under Secretary for Health, concurred with our findings and recommendations and stated that VHA will address Recommendations 7 and 8 with new TPA contract requirements for its CCN. VHA expects the CCN agreement to phase out the use of Choice by the time the current contract expires in September 2018.

To address Recommendation 7, the Executive in Charge reported that while timeliness was an issue with the sample audited, this occurred while using FBCS to adjudicate claims (a highly manual system) and adequate capacity to meet the demand did not exist. Choice claims processing has since moved toward a more automated environment and timeliness of payments using FSC Plexis Claims Manager has maintained a standard of 99.5 percent paid within 30 days of receipt of clean claims.

To address Recommendation 8, the Executive in Charge reported that VHA has now included specific requirements in the new CCN contract. The contract will require TPAs to process 98 percent of all clean claims within 30 days of receipt, return claims needing correction within 30 days to the submitting provider, and process corrected claims within 30 days of resubmission. TPAs will receive incentive payments if contract performance standards are met.

**OIG Response**

The Executive in Charge for the Office of the Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all actions are completed in both the existing Choice Program and the future CCN. As of December 2017, VHA has not provided us evidence necessary

to close Recommendations 7 and 8. Once evidence is received and examined, we will determine if VHA's actions are sufficient to close the recommendations. The Executive in Charge's entire response can be found in Appendix E.



## Appendix A Background

### Veterans Choice Program Relationship to Patient- Centered Community Care

Choice was preceded by the PC3 program. In September 2013, VA awarded the initial PC3 contracts to Health Net and TriWest as a supplement to the non-VA care program. The contracts totaled approximately \$5.1 billion for Health Net and \$4.4 billion for TriWest. The PC3 Program began health care delivery in January 2014.

PC3 is a nationwide VHA program that offers health care to eligible veterans through service contracts when local VHA medical facilities have exhausted options for purchased care and cannot readily provide care due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. PC3 provides eligible veterans with access to primary care and mental health care, inpatient and outpatient specialty care, limited emergency care, and limited newborn care for enrolled female veterans following delivery.

In October 2014, VA amended the PC3 contracts with Health Net and TriWest to include the administration of Choice. The contract modifications, valued at \$300 million, required contractors to perform these administrative tasks:

- Print and distribute Choice cards to all eligible veterans
- Provide a high-quality network of providers
- Establish call centers to assist veterans
- Schedule appointments with network providers
- Provide medical documentation to VHA following non-VA health care

### Eligibility

VACAA (as amended) requires veterans enrolled in VA's health care system to meet one of the following criteria to be eligible for care under Choice:

- Attempts to schedule an appointment with VA under Title 38 United States Code (Chapter 17) but cannot be seen within VHA's wait-time goal of 30 days
- Resides more than 40 miles from a VHA medical facility
- Resides less than 40 miles from the VHA medical facility and must travel by air, boat, or ferry to reach such a facility
- Resides less than 40 miles from the VHA medical facility and faces an unusual or excessive burden in accessing such a facility
- Resides in a state without a VHA medical facility

**Reimbursement Rates**

According to the PC3/Choice contracts, the Choice payment process follows the Medicare payment guidelines applicable to the type of service authorized and performed. Choice claims are paid based on the contracted Medicare rate. If there is no established Medicare rate for the care being provided, the VA Fee Schedule will be used.

**Parties Involved in Payment of Choice Claims**

The parties involved in the Choice payment process include:

**Office of Community Care:** OCC provides program direction and oversight of the Choice Program. OCC represents a single accountable authority for development of the administrative processes, policies, regulations, and directives associated with the delivery of VA health benefit programs. As a principal health benefits administration advisor to the Under Secretary for Health, OCC develops, implements, and supports various aspects of administrative health care issues.

**Financial Services Center:** FSC is under an agreement with OCC to provide Choice claims services. FSC is a service center that performs Choice claims processing on behalf of OCC. An SLA between FSC and OCC outlines the scope of FSC's responsibility, which is to process payments for a fee. FSC signed an SLA to process Choice claims in June 2015.

**Third Party Administrators:** TPAs are responsible for establishing networks of non-VA providers to meet the medical needs of eligible veterans. TPAs are also responsible for establishing call centers, scheduling appointments, and coordinating the transmission of medical documents between OCC and non-VA providers. TPAs pay providers for service connected and non-service connected care and services at the rates negotiated in accordance with Choice or PC3.

**Providers:** Providers are defined in the contract as a hospital, clinic, health care institution, health care professional, or group of health care professionals who provide health care services to veterans. Providers are responsible for billing OHI before submitting claims. Providers receive payment directly from the TPAs.

**OCC Choice Claims Paid in FYs 2015 and 2016**

From November 1, 2014 through September 30, 2016, OCC paid about 2 million claims for about \$649 million to the TPAs. Payments to the TPAs grew significantly from the first year of the Choice Program, increasing about \$618 million or 4,100 percent.

Table 10 summarizes OCC payments to TPAs for the first two years of the Choice Program.

**Table 10. Dollars Paid by OCC to TPAs**

<b>TPA</b>	<b>FY 2015*</b>	<b>FY 2016</b>	<b>Total</b>
Health Net	\$1,131,573	\$67,642,718	\$68,774,290
TriWest	\$14,036,651	\$565,670,257	\$579,706,909
<b>Total</b>	<b>\$15,168,223</b>	<b>\$633,312,975</b>	<b>\$648,481,199</b>

*Source: VA OIG analysis of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

*\* FY 2015 figures cover November 1, 2014 through September 30, 2015*

## Appendix B Scope and Methodology

### Scope

We performed our audit from January 2016 to November 2017 to determine the accuracy and timeliness of Veterans Choice Program (Choice) payments. Our audit included Choice claims processed in FBCS for payment to the TPAs from November 1, 2014 through September 30, 2016. We did not audit bulk Choice medical payments processed outside of FBCS,<sup>49</sup> Choice administrative payments, or payments for Hepatitis C and other non-Department care that used Choice Program funding.

### Methodology

We reviewed the PC3/Choice contracts and interviewed officials from OCC, FSC, the Denver Acquisition and Logistics Center, Health Net, and TriWest. We used a third-party vendor to evaluate medical claims in our audit sample to determine if the Medicare rates applied were correct.

Choice payment data were obtained from VA's Central Fee files and statistically sampled for each TPA. We reviewed a sample of payment transactions from the approximately \$649 million paid to the Health Net (\$69 million) and TriWest (\$580 million) from November 1, 2014 through September 30, 2016, via FBCS. For each sample item, we compared the paid claim to other paid claims in the sample universe to determine if the paid claim was a duplicate claim. Payment accuracy was reviewed for payments made by VA to the TPA by comparing the amounts paid for each CPT code to either the Medicare Reimbursement rate or to the VA Fee Schedule rate, when there was no established Medicare rate. To determine if VA had primary or secondary payment responsibility for Choice claims, we reviewed the veteran's service connection and OHI information in VA's Computerized Patient Record System and Veterans Health Information Systems and Technology Architecture records. Payment timeliness was calculated by comparing the date VA received TPA claims to the date of VA disbursements; and the dates of when the TPA received a provider claim to the date of the TPA's payment to the provider.

To aggregate and estimate an overall rate of payment errors, we created an error hierarchy. The purpose of the error hierarchy was to establish a methodology for determining a category to report a payment error when the sample item fell into more than one category. We used the following hierarchy for our payment processing errors so as not to double count errors that occurred in multiple categories: pass-through errors, pricing errors, and

---

<sup>49</sup> PC3/Choice contracts were modified in March through November 2016 to allow VCPBYPASS (payments for Choice medical claims that were not submitted to VA by the TPAs due to missing medical documentation) and Expedited payments for Choice medical care to TPAs. We refer to these transactions as "bulk payments" for the purpose of our report. Because these bulk payment processes were not in place when this review was planned, a second audit was started in April 2017 to address the accuracy of payments under the bulk payment process.

duplicate errors. We counted OHI errors independently because an OHI error would be recoverable from a veteran's OHI and also be subject to adjustment if paid as a pass-through, pricing, or duplicate error.

**Fraud  
Assessment**

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence
- Reviewing providers' claim and remittance advice information provided by the TPAs

**Data  
Reliability**

To test the reliability of computer-processed data, we extracted Choice expenditures from VA's Central Fee files from November 1, 2014 through September 30, 2016. We performed these steps for 97 claims from our statistical sample:

- We independently queried VA's Central Fee files and compared key fields (Veteran Last Name, Social Security Number, Treatment Date, CPT code, Disbursed amount) to medical claims submitted via Electronic Data Interchange by the TPA to VA.

We received the date providers submitted medical claims to the TPA from Health Net and TriWest. To test the reliability of this data we performed these steps:

- We compared the provider physician signature date on provider claims and, if needed, compared that information with medical documentation within the TPA's portal.

We concluded the data were valid and sufficiently reliable to support our audit's objectives and conclusions.

**Government  
Standards**

We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

## Appendix C Statistical Sampling Methodology

To determine the accuracy and timeliness of Choice Program payments, we sampled paid claims for Health Net and TriWest from November 1, 2014 through September 30, 2016.

**Population** We identified 1,977,619 paid claims that resulted in \$648,481,199 of Choice expenditures for the period of November 1, 2014 through September 30, 2016, for both outpatient and inpatient care.

**Sampling Design** We divided our population into four strata. For each TPA, Health Net and TriWest, we further stratified by the type of care, either inpatient or outpatient. Analysis was then performed on a sample pulled from each strata on a quarterly basis, starting with FY 2015, Quarter 1 through FY 2016, Quarter 4. Table 11 describes the total sample items for each category.

**Table 11. Sample Size by Fiscal Quarter**

TPA	2015 Q2	2015 Q3	2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	Total
Health Net	30	30	30	33	64	60	60	307
TriWest	0	35	60	60	64	60	60	339
<b>Total</b>	<b>30</b>	<b>65</b>	<b>90</b>	<b>93</b>	<b>128</b>	<b>120</b>	<b>120</b>	<b>646</b>

*Source: VA OIG sample size by fiscal quarter determined by OIG Statistician*

**Weights** We calculated all estimates in this report using weighted sample data. Weighted sample data is the result of assigning a weight to each sample item to adjust the sample item to represent the population from which the sample was drawn. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling. For example, we calculated error rate estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the total sum of the weights.

**Projections and Margins of Error** The point estimate (estimated error) is a parameter of a particular numerical value of the estimator obtained by sampling and the margin of error is the degree of accuracy of the point estimate. The margin of error assesses the amount of uncertainty inherent in any sampling process. The confidence level is the probability, the relative frequency of occurrence of an event, associated with a range of values that may contain or describe an unknown parameter. The confidence level expresses the proportion of times that the statistical conclusion is correct, in other words it measures the confidence or degree of belief in the confidence interval estimate.

The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the estimates and confidence intervals would differ for each sample but the confidence intervals would include the true population value 90 percent of the time. Tables 12 through 20 show the error rates and estimates based on our analysis of sample items. For some attributes we found a low error rate; therefore, the actual margin of error (and hence the difference between the upper and lower limits of the confidence interval) as measured by the analysis of the sample data is much larger than what was expected when designing the sample, which anticipated a higher rate of errors.

**Table 12. Estimated Number of Payment Errors**

TPA	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%	Actual Error
<b>Health Net</b>					
Duplicate Errors	5,155	4,879	3	10,034	3
Pass-Through Errors	55,167	14,613	40,555	69,780	48
Payment Rate Errors	1,718	2,831	1	4,549	1
OHI Errors	17,742	8,767	8,975	26,509	15
<b>TriWest</b>					
Duplicate Errors	25,561	24,174	3	49,735	3
Pass-Through Errors	-	-	-	-	-
Payment Rate Errors	39,716	27,917	11,799	67,633	21
OHI Errors	78,671	41,184	37,486	119,855	15
<b>Weighted Estimate for TriWest and Health Net</b>					
Duplicate Errors	30,716	24,662	6	55,377	6
Pass-Through Errors	55,167	14,613	40,555	69,780	48
Payment Rate Errors	41,434	28,061	13,374	69,495	22
OHI Errors	96,413	42,107	54,306	138,520	30
<b>Total</b>	<b>223,730</b>	<b>36,315</b>	<b>163,910</b>	<b>283,550</b>	<b>104</b>

*Source: VA OIG Payment Accuracy Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

**Table 13. Estimated Percentage of Payment Errors**

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
<b>Weighted Estimate for TriWest and Health Net</b>				
Duplicate Errors	1.6	1.3	0.0	2.8
Pass-Through Errors	2.8	0.7	2.1	3.5
Payment Rate Errors	2.1	1.4	0.7	3.5
OHI Errors	4.9	2.1	2.8	7.0
<b>Total</b>	<b>11.3</b>	<b>1.8</b>	<b>8.3</b>	<b>14.2</b>

*Source: VA OIG Payment Accuracy Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*



**Table 14. Estimated Dollar Amount of Payment Errors\***

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
<b>Health Net</b>				
Duplicate Errors	\$646,804	\$882,586	\$376	\$1,529,390
Pass-Through Errors	\$1,837,801	\$688,682	\$1,149,119	\$2,526,483
Payment Rate Errors	\$270,091	\$444,902	\$115	\$714,992
<b>TriWest</b>				
Duplicate Errors	\$3,119,585	\$4,084,983	\$743	\$7,204,568
Pass-Through Errors	-	-	-	-
Payment Rate Errors	\$26,633,037	\$10,000,848	\$16,632,189	\$36,633,884
<b>Weighted Estimate for TriWest and Health Net</b>				
Duplicate Errors	\$3,766,389	\$4,179,239	\$743	\$7,945,628
Pass-Through Errors	\$1,837,801	\$688,682	\$1,149,119	\$2,526,483
Payment Rate Errors	\$26,903,127	\$10,010,739	\$16,892,388	\$36,913,866

Source: VA OIG Payment Accuracy Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016

\* Projected amount for OHI errors was not estimated because amount of insurance reimbursement for each claim could not be determined since there were no EOBs documenting the exact amount OHI would have paid for the medical services provided.

**Table 15. Estimated Number of Timeliness Errors OCC to TPAs**

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
<b>Health Net</b>				
≤ 30 days	183,622	20,671	162,951	204,294
>30 days	191,278	20,671	170,606	211,949
<b>TriWest</b>				
≤ 30 days	773,743	94,897	678,846	868,640
>30 days	828,976	94,897	734,079	923,873
<b>Weighted Estimate for TriWest and Health Net</b>				
≤ 30 days	957,365	97,122	860,243	1,054,487
>30 days	1,020,254	97,122	923,132	1,117,376

*Source: VA OIG Payment Timeliness Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

**Table 16. Estimated Percentage of Timeliness Errors OCC to TPAs**

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
<b>Health Net</b>				
≤ 30 days	49.0	5.5	43.5	54.5
> 30 days	51.0	5.5	45.5	56.5
<b>TriWest</b>				
≤ 30 days	48.3	5.9	42.4	54.2
> 30 days	51.7	5.9	45.8	57.6
<b>Weighted Estimate for TriWest and Health Net</b>				
≤ 30 days	48.4	4.9	43.5	53.3
>30 days	51.6	4.9	46.7	56.5

*Source: VA OIG Payment Timeliness Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016*

**Table 17. Estimated Number of Timeliness Errors TPA to Provider**

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
<b>Health Net</b>				
≤ 30 days	134,323	19,880	114,443	154,203
> 30 days	240,577	19,880	220,697	260,457
<b>TriWest</b>				
≤ 30 days	650,617	93,495	557,121	744,112
> 30 days	952,102	93,495	858,607	1,045,598
<b>Weighted Estimate for TriWest and Health Net</b>				
≤ 30 days	784,940	95,586	689,354	880,525
> 30 days	1,192,679	95,586	1,097,094	1,288,265

*Source: VA OIG Payment Timeliness Projections for TPA payments to providers based data obtained from Health Net and TriWest for each of our sample items for the period of November 1, 2014 through September 30, 2016*

**Table 18. Estimated Percentage of Timeliness Errors TPA to Provider**

TPA	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
<b>Health Net</b>				
≤ 30 days	35.8	5.3	30.5	41.1
> 30 days	64.2	5.3	58.9	69.5
<b>TriWest</b>				
≤ 30 days	40.6	5.8	34.8	46.4
> 30 days	59.4	5.8	53.6	65.2
<b>Weighted Estimate for TriWest and Health Net</b>				
≤ 30 days	39.7	4.8	34.9	44.5
> 30 days	60.3	4.8	55.5	65.1

Source: VA OIG Payment Timeliness Projections for TPA payments to providers based on data obtained from Health Net and TriWest for each of our sample items for the period of November 1, 2014 through September 30, 2016

**Table 19. Estimated Average Number of Days for OCC To Pay TPAs**

TPA	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net	36.6	1.8	34.8	38.4
TriWest	36.3	2.4	33.9	38.6
Weighted Estimate for TriWest and Health Net	36.3	2.0	34.4	38.3

Source: VA OIG Payment Timeliness Projections based on a sampled universe of paid Choice claims obtained from VA Central Fee for the period of November 1, 2014 through September 30, 2016

**Table 20. Estimated Average Number of Days for TPAs To Pay Providers**

<b>TPA</b>	<b>Estimated Error</b>	<b>Margin of Error</b>	<b>Confidence Interval Lower Limit 90%</b>	<b>Confidence Interval Upper Limit 90%</b>
Health Net	47.3	4.6	42.7	51.8
TriWest	39.2	3.3	35.8	42.5
Weighted Estimate for TriWest and Health Net	40.7	2.8	37.9	43.5

*Source: VA OIG Payment Timeliness Projections for TPA payments to providers based on data obtained from Health Net and TriWest for each of our sample items for the period of November 1, 2014 through September 30, 2016*

## Appendix D Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Fund	Questioned Costs
4	Improve Choice payment processing system to prevent improper payments and recover overpayments. Questioned costs consist of payments made that did not meet the PC3/Choice contract payment criteria, payments made at improper contract rates, without proper adjustment, or for duplicate claims. <i>See note below.</i>	\$0	\$39 Million
<b>Total</b>		<b>\$0</b>	<b>\$39 Million</b>

*Note: We considered the approximate \$39 million in questioned costs to be improper payments. OMB Circular A-123 Appendix C defines an improper payment as any payment that should not have been made or that was made in an incorrect amount under contractual requirements, including duplicate payments.*

## Appendix E Management Comments

### Department of Veterans Affairs Memorandum

Date: 12/08/2017

From: Executive In Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (VAIQ 7857103)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report, *Audit of Veterans Choice Program Payment Accuracy and Timeliness*. The Veterans Health Administration (VHA) concurs with recommendations 1, 3, and 5-8, concurs in principle with recommendations 2 and 4, and provides the attached action plan.
2. The Department of Veterans Affairs (VA) is actively working to resolve issues related to payment errors to Third Party Administrators (TPAs), particularly those where funds are allotted to spending pursuant to the Choice Act. As the OIG has noted in its Choice reports, VA had an extremely short timeline to implement the Choice Act and due to a number of factors, the Department experienced delays in payments to both Health Net and TriWest. These delays frustrated the contractors' financial ability to sustain community provider networks, and undermined their ability to recruit and retain providers. As a result, it was necessary for VA to change its payment methods for Choice and it was understood that there would be significant initial reliance on post-payment Choice payment reviews and audits. While payments made to TPAs under the Veterans Choice Program are no longer processed through the Fee Basis Claim System, the recommendations made in this report remain relevant to the current state of Choice and will remain important considerations during the implementation of the Community Care Network.
3. As described in VHA's action plan, many improvements have been implemented by the VHA Office of Community Care (OCC) and the VA Financial Services Center (FSC) to improve the timeliness and accuracy of Choice payments since the outset of the program. We have also improved our internal assessment tools. In early 2017, VHA OCC conducted an internal audit that indicated duplicate payments were an area of particular concern to TPAs. Using VHA OCC's Program Integrity Tool (PIT), an electronic system that supports advanced data analytics, greater than \$80 million in potential duplicate payments were identified through an analysis of all payments made through the Choice expedited payment process. This information has been shared with the VA OIG and the TPAs. As a result of this information, in July 2017, VHA OCC began using the PIT tool to conduct pre-payment analysis of all Choice claims paid through the expedited payment process. To date, more than \$19 million in potential overpayments have been prevented.
4. The VA FSC also processes Choice claims and, similar to VHA OCC, utilizes an automated tool to detect and prevent duplicate payments prior to payment. In addition, the FSC is currently conducting post-payment pricing reviews on Choice claims processed by both OCC and the FSC in fiscal year 2017 with the intent to use this information to recover any identified overpayments. Using their automated claims payment system, timeliness has also improved, and currently 99.5 percent of clean claims submitted by TPAs are paid within 30 days by the FSC.
5. It is important to note that in the Choice Program the TPAs are responsible for adjudicating claims, paying providers, and invoicing VA timely and accurately. VHA incorporated more stringent requirements for timeliness and accuracy of payments into the upcoming Community Care Network Request for Proposals. This includes a requirement that TPAs procure third party auditors to



continually review payments for accuracy. VHA will also continue strengthening its internal payment processes and analytic tools and incorporate additional accuracy checks while maintaining timely payments to our TPAs.

6. VHA agrees with the OIG that a full review of payments made under the Veterans Choice Program and recovery of all identified overpayments is essential. We will continue to work collaboratively with the VA Office of General Counsel, OIG, and all other relevant government stakeholders to ensure that Choice payments are thoroughly reviewed and all overpayments are recovered.
7. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at [VHA10E1DMRSAction@va.gov](mailto:VHA10E1DMRSAction@va.gov).

Carolyn M. Clancy, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Action Plan**

**OIG Draft Report: Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System**

**Date of Draft Report: November 21, 2017**

Recommendations/ Actions	Status	Completion Date
-----------------------------	--------	-----------------

Recommendation 1: We recommended the Executive in Charge, Veterans Health Administration develop and issue written payment policies to guide staff processing medical claims received from Third Party Administrators as well as establish expectations and obligations for the Third Party Administrators that submit invoices for payment.

VHA Comments: Concur.

VHA agrees that clear policies and procedures are necessary for claims processors and third party administrators. The Department of Veterans Affairs (VA) Financial Services Center (FSC) currently uses the Plexis Claims Manager (PCM) system to process Choice claims for VA. A PCM Choice User Manual has been developed and formal training has been completed to FSC staff.

With knowledge that the Veterans Choice Program will end once funds are exhausted, VHA looks toward the award of its future Community Care Network (CCN) contracts which constitute the future state of payment and claims processing to Third Party Administrators (TPA). VA anticipates awarding the first region-based contract by the end of calendar year 2017, with the remaining regions to be awards throughout calendar year 2018. A Contractor Claims Processing Standard Operating Procedure (SOP) and VHA Office of Community Care (OCC) Claims Processing SOP are being developed to clearly outline procedures and expectations for VA employees and TPAs.

VHA will provide the following documentation at completion of this action:

- PCM Choice User Manual (FSC employee processes for Choice)
- Contractor Claims Processing SOP (outlines contractor facing processes)
- OCC Claims Processing SOP (outlines VA processes)

Status: In Process

Target Completion Date: January 2018

Recommendation 2: We recommended the Executive in Charge, Veterans Health Administration ensure payment processing staff have access to documentation from the Third Party Administrators verifying amounts paid to providers to ensure the Third Party Administrators are not billing VA more than they paid the provider for medical claims.

VHA Comments: Concur in principle.

VA recognizes that in the current Choice contract, Third Party Administrators (TPA) are not required to submit documentation to show the amount paid by them to Community Providers. Given that the Veterans Choice Program will end once funds have been exhausted, VHA will focus on improvements that can be accomplished during implementation of the Community Care Network (CCN).

The CCN Request for Proposals (RFP) requires that TPAs submit documentation indicating the amount paid to Providers. This will allow VHA staff to ensure that TPAs are not billing VA more than they paid the provider.

VHA will provide the following documentation at completion of this action:

- CCN RFP (section 12.6)

Status: Complete

Completion Date: December 2017

Recommendation 3: We recommend the Executive in Charge, Veterans Health Administration ensure Veterans Health Administration payment staff have access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.

VHA Comments: Concur.

VHA agrees that access to accurate information regarding other health insurance and appropriate policies and procedures for collecting payments is essential. The Community Care Network (CCN) Request for Proposals (RFP) includes additional process requirements that will ensure that claims processing staff have access to Veterans' health insurance information to accurately assess coordination of benefits requirements. In addition, processes for VA employees and Third Party Administrators (TPA) will be clearly outlined in the Standard Operating Procedures (SOP) being created.

VHA will provide the following documentation at completion of this action:

- CCN RFP (section 12.7)
- Contractor Claims Processing SOP (outlines contractor facing processes)
- OCC Claims Processing SOP (outlines VA processes)

Status: In Process

Target Completion Date: March 2018

Recommendation 4: We recommended the Executive in Charge, Veterans Health Administration ensure the new payment processing systems used for processing medical claims from Third Party Administrators have the ability to adjudicate reimbursement rates accurately and to ensure duplicate claims are not paid.

VHA Comments: Concur in principle.

VHA ended the use of the Fee Basis Claims System (FBCS) system to process Choice claims in fall 2016. Currently, Choice claims are processed in two ways depending on their service date, either through the expedited payment process by VHA OCC or through the Plexis Claims Manager (PCM) by the Financial Services Center (FSC). As detailed in our response to recommendation 5, VHA recognized that additional internal controls were necessary to improve payment accuracy and has put additional measures into place. As of July 2017, OCC utilizes its Program Integrity Tool (PIT), an electronic tool with advanced data analytic capabilities, to identify duplicate payments prior to payment for Choice expedited payments. To date, potential duplicate payments totaling greater than \$19 million have been prevented using this process.

A duplicate analysis is also occurring prior to payment for claims processed using PCM by the FSC. Furthermore, in January 2018, the FSC anticipates incorporating pre-payment pricing reviews to the functionality of PCM. The FSC is also currently conducting post-payment pricing reviews of Choice expedited and PCM processed payments.

The proposed Community Care Network (CCN) will incorporate a number of improvements based on lessons learned from implementation of the Veterans Choice Program. VHA will use a Commercial off

the Shelf (COTS) system as foundation for a new reimbursement system that includes inherent Fraud, Waste and Abuse (FWA) tools, data analytics, and financial measures. Prepayment analytics will include identification of duplicate claims, out of network provider claims, and use of the List of Excluded Individuals and Entities (LEIE) database.

It is important to note that in the Choice Program as well as in the proposed Community Care Network, the Third Party Administrators (TPA) are responsible for adjudicating and paying health care claims to community providers. VA recognizes that additional contractual guidelines are necessary to ensure that payments from TPAs to Community Providers and subsequent invoices to VHA are completed accurately and timely. These standards have been included in the CCN Request for Proposals (RFP).

Key items of note from the CCN RFP (full RFP will be provided for OIG review) include:

- The TPA is fully responsible for ensuring VA is invoiced in accordance with the contract pricing and payments guidelines and only for services authorized through an Approved Referral.
- The TPA must share information when fraud, waste, or abuse (FWA) is substantiated for any payments for which they were reimbursed by VA.
- The TPA must hire a third party auditor who is a member with the American Institute of Certified Public Accountants (AICPA) to do the following:
  - Validate the proper configuration of the TPA's payment system to ensure proper payments.
  - Ensure that FWA detection analytics are inherent in its claims processing system.
  - Conduct a review of the complete universe of health care service payments which the contractor submits to VA for reimbursement to determine the percentage and dollar amount of improper payments in the program as well as recoveries for overpayments that result in a loss to VA.
  - The review must always ensure the most current published Centers for Medicare and Medicaid Services (CMS), VA fee schedule and other applicable contract payment schedules which correspond to the period the services were rendered are utilized when determining if a payment was accurate.

Clear incentives/disincentives have also been built into the CCN RFP to further support payment accuracy.

VHA will provide the following documentation at completion of this action:

- CCN RFP
- Community Care Reimbursement System (VHA's reimbursement system to TPAs) policies and procedures.

Status: In Process

Target Completion Date: March 2018

Recommendation 5: We recommended the Executive in Charge, Veterans Health Administration ensure VA performs post-payment audits on a periodic basis to determine if payments made to Third Party Administrators for medical care are accurate.

VHA Comments: Concur.

At present, VHA Office of Community Care (OCC) and the Financial Services Center (FSC) are performing a number of post-payment reviews to assess payment accuracy that were previously not in place in the Fee Basis Claims System (FBCS) environment.

In early 2017, VHA OCC's internal audit team presented results from an internal audit that indicated duplicate payments to Third Party Administrators (TPA) were an area of concern. Through the use of the Program Integrity Tool (PIT), OCC completed a detailed post payment analysis of Choice expedited payments and identified more than \$80 million in potential duplicate payments. This data was shared with the VA OIG and sent to the TPAs in July 2017 for review.

OCC is now utilizing the PIT tool to identify and prevent duplicate payments prior to payment in the expedited payment environment. For Choice claims processed by the VA Financial Services Center (FSC), pre-payment analysis is also occurring through use of their Plexis Claims Manager (PCM). Additionally, the FSC is currently performing post-payment pricing analyses of Choice claims paid in both the expedited payment and PCM environments.

The 2018 VA Community Care (VACC) Improper Payments Elimination and Recovery Act (IPERA) audit universe will contain Choice claims paid using a) provider agreements, b) expedited payments, and c) Choice Quick Pay payment processes. The OCC Internal Audit Team is in the process of conducting an audit of the Choice Quick Pay payment process. Audit findings and associated corrective actions will be shared with OIG upon completion.

As noted in VA's response to recommendation 4, the Community Care Network (CCN) Request for Proposals (RFP) mandates that TPA's hire an independent third party auditor to ensure payment accuracy and incentives/disincentives have been incorporated into the CCN RFP based on payment accuracy. OCC's internal audit team will also develop an audit plan for CCN payments.

VHA will provide the following documentation at completion of this action:

- Applicable internal audit reports
- CCN RFP
- Overpayment data identified using the PIT and FSC tools as requested by VA and applicable government authorities (as per recommendation 6)

Status: In process

Target Completion Date: December 2018

Recommendation 6: We recommended that the Executive in Charge, Veterans Health Administration ensure that Office of Community Care staff and members of VA's Office of General Counsel continue to work collaboratively with relevant government authorities to review and determine an appropriate process for reimbursement.

VHA Comments: Concur.

VHA's Office of Community Care (OCC) will continue to work collaboratively with the VA Office of General Counsel (OGC), OIG, and all relevant government authorities to pursue an appropriate reimbursement process for identified Choice overpayments. OCC's internal audit findings and data analytics results have been shared with the VA OGC and OIG in detail, including data regarding more than \$80 million dollars in potential duplicate payments that were identified using the Program Integrity Tool (PIT). OCC representatives continue to meet regularly with VA OIG and are participating fully in all requested activities by the OIG and other relevant government agencies. OCC will continue to do so until this matter is fully resolved.

VHA will provide the following documentation at completion of this action:

- The nature of this action does not require that a concrete deliverable be submitted although, as noted above, OCC will continue to fully comply with all requests from the VA OIG and other relevant government authorities.

Status: In Process

Target Completion Date: TBD (a final completion date for this action will be determined by VA OIG)

Recommendation 7: We recommended the Executive in Charge, Veterans Health Administration ensure the Veterans Health Administration has sufficient claims processing capacity to timely meet and process expected claim volume from the Third Party Administrators.

VHA Comments: Concur.

While timeliness was an issue with the sample audited, this was while using Fee Basis Claims System (FBCS) to adjudicate claims (a highly manual system) and adequate capacity to meet the demand did not exist. Choice claims processing has since moved toward a more automated environment and timeliness of payments using Financial Services Center (FSC) Plexis Claims Manager (PCM) has maintained a standard of 99.5 percent paid within 30 days of receipt of clean claims.

VHA will provide the following documentation at completion of this action:

- Documentation of timeliness of processing to contractors.

Status: Complete

Target Completion Date: December 2017

Recommendation 8: We recommend the Executive in Charge, Veterans Health Administration ensure that future contracts with Third Party Administrators contain payment timeliness standards for the processing of claims from health care providers.

VHA Comments: Concur.

VHA recognizes that our current Veterans Choice Program (VCP) contracts do not define a mechanism to monitor or ensure the timeliness of Third Party Administrator (TPA) payments to providers. These contracts also do not provide VA the authority to ensure the TPA pays their network providers in a timely manner. However, the contract modification, which eliminated medical documentation as a requirement for payment, signed in February 2016, also created a goal for the TPAs to make payments to providers "within 30 calendar days of receipt of a clean claim." This contract modification also included language that stipulates that TPAs may not invoice VA for services for which the community provider has not yet been paid. However, no penalty is in place if these or other clauses are not met.

VHA included specific requirements that address this recommendation in the released Community Care Network (CCN).

The targeted goals specified in Section B.16, Sections 12 and 12.4 (page 105 of 210) of the CCN Request for Proposals (RFP) include:

- TPA must always process 98 percent of all clean claims within 30 days of receipt
- TPA must always return claims, other than clean claims to the provider with a clear explanation of deficiencies within 30 days of original receipt
- TPA must process corrected claims within 30 days or reimbursement resubmission.

Performance will be measured by calculating the number of provider claims processed on the first pass divided by the total number of provider claims the contractor receives in a 180-day period. If the contractor receives 90 percent or more clean claims, a 1 percent increase of the cumulative Per-Member-Per-Month fee will be paid. If performance is less than 90 percent, no incentive will be paid. Performance will be monitored by the VHA Office of Community Care and the Contracting Officer.

VHA will provide the following documentation at completion of this action:

- CCN RFP

Status: Complete

Target Completion Date: December 2017

*For accessibility, the format of the original documents in this appendix has been modified to fit in this document, to comply with Section 508 of the Americans with Disabilities Act.*

## Appendix F **OIG Contact and Staff Acknowledgments**

---

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
---------	---

---

Acknowledgments	Matthew Rutter, Director Chris Enders Todd Groothuis Michael Kelly Solida Nhem Loi Pham Melinda Toom Barbara Wright
-----------------	--

## **Appendix G Report Distribution**

### **VA Distribution**

Office of the Secretary  
Veterans Benefits Administration  
Veterans Health Administration  
National Cemetery Administration  
Assistant Secretaries  
Office of General Counsel  
Office of Acquisition, Logistics, and Construction  
Board of Veterans' Appeals

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction,  
Veterans Affairs, and Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction,  
Veterans Affairs, and Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget

**This report is available on our website at [www.va.gov/oig](http://www.va.gov/oig).**