



# Department of Veterans Affairs Office of Inspector General

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## Review of Enterprise Technology Solutions, LLC Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations

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## Executive Summary

The VA Office of Inspector General (OIG), Office of Contract Review, initiated and conducted a review of Enterprise Technology Solutions, LLC's (ETS) compliance with subcontracting limitations contained in its five contracts for claims re-pricing. These contracts were awarded in 2007 and 2008 for a base year plus four one-year option periods. ETS is a service-disabled veteran-owned small business (SDVOSB) concern. All five contracts for claims re-pricing were awarded as SDVOSB set-asides. Claims re-pricing is the process of comparing VA allowable rates based on fees charged by non-VA health care providers to rates that the contractor may have established with health care providers who are a part of their network. If the network rates are lower than the VA allowable rates, the contractor re-prices the claim and calculates the potential savings. The re-pricing contractor, ETS, then receives a percentage of the potential savings as a fee under the contract.

Our review determined that ETS was not in compliance with the contract provisions limiting subcontracting. We determined that ETS subcontracted all of the claims re-pricing tasks under all five contracts to its subcontractor Health Net Federal Services (Health Net). We found that Health Net, a large business, was doing claims re-pricing work for VA prior to the ETS contracts. According to the ETS Program Manager, Health Net encouraged the owner of ETS (Mr. Donald Neilson, a former VA employee) to start ETS as an SDVOSB concern, which allowed Health Net to increase business by subcontracting with an SDVOSB that obtained the contract through a small business set-aside. As VA was consolidating its claims re-pricing contracting at the Health Administration Center (HAC) in Denver, Colorado, VA changed the acquisitions for re-pricing services to SDVOSB set-asides. ETS and another SDVOSB, Primeaux (subsequently acquired by ETS in April 2009) were awarded the claims re-pricing contracts and both used Health Net to actually process and re-price the claims.

We concluded that ETS did not process any of the claims nor did they have the expertise or capability of re-pricing claims and never intended to perform the work despite the terms and conditions of the contracts. VA personnel responsible for administering the contracts were fully aware that ETS was subcontracting all of the work to Health Net in violation of the provision in the contract limiting subcontracting because ETS had VA forward all claims directly to Health Net for processing. In fact, ETS never actually handled the claims in any manner. ETS's sole function was to use its SDVOSB status to obtain the contract on behalf of Health Net.

Based on our review of the acquisition planning and other relevant documents, we determined the SDVOSB set-asides were not properly justified. We found no evidence that VA conducted any analysis to determine if there were any SDVOSB concerns that were capable of performing the required work.

We note that this is the third report issued by the OIG identifying improper sole-source contracting by the Veterans Health Administration (VHA) to former VA employees who have formed or work for SDVOSBs. (*Department of Veterans Affairs Office of Inspector General Review of Allegations of Improper Contract Awards to Watkins Sinclair, LLC, Report No. 09-02322-192; Administrative Investigation, Improper Contracts, Conflict of Interest, Failure to Follow Policy, and Lack of Candor, Health Administration Center, Denver, Colorado, Report No. 10-02328-154.*)

We recommended that the Chief Procurement and Logistics Officer terminate the five ETS contracts for claims re-pricing for default and that the Chief Procurement and Logistics Officer coordinate with the Under Secretary for Health to determine if there is a need for any contract(s) to re-price non-VA care fee claims. We also recommended that VHA ensure that the requirements for future contracts do not preclude competition when the vendor is a former VA employee or composed primarily of VA employees. We referred the issues identified in our review to the OIG Office of Investigations and will refer ETS to VA's Suspension and Debarment Committee for possible action in accordance with FAR Subpart 9.4 and VAAR Subpart 809.406.

We recommended that the Under Secretary for Health establish procedures to ensure that all non-VA fee claims are submitted to VA's Medicare pricer to determine the appropriate Medicare rate. We also are recommending that the Under Secretary for Health determine whether claims re-pricing for non-VA care have resulted in rates that are lower than Medicare rates and achieved in any actual savings taking into consideration the fee paid for the re-pricing services. We also recommended that the Under Secretary for Health implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition or give former VA employees an unfair advantage and to ensure the appropriate approvals are in place to ensure competition to the maximum extent practicable.

The Chief Procurement and Logistics Officer and the Under Secretary for Health concurred with our findings and recommendations and provided comments. Their comments and planned actions are attached to this report. We believe their planned course of action addresses our finding and recommendations. We will follow up on the planned actions until implemented.



MARK A. MYERS  
Director, Healthcare Resources Division  
Office of Contract Review

## Introduction

### Purpose

In January 2012, the Office of Inspector General (OIG), Office of Contract Review initiated a review on five contracts for re-pricing of non-VA health care providers' claims with Enterprise Technology Solutions, LLC (ETS). The primary purpose was to determine whether ETS was in compliance with the contract terms and conditions limiting subcontracting.

### Background

During 2007 and 2008, the Health Administration Center (HAC) in Denver, Colorado, awarded five contracts for re-pricing claims submitted by non-VA health care providers.<sup>1</sup> The five contracts covered five different regions that the HAC created by grouping several Veterans Integrated Service Networks (VISNs) together for the purpose of re-pricing claims. These procurements were all conducted as service-disabled veteran-owned small business (SDVOSB) set-asides. VA awarded these five contracts to two different SDVOSB companies. ETS was awarded three contracts<sup>2</sup> for Region 5 (VISNs 19, 20, 21, and 22), Region 1 (VISNs 1, 2, 3, 4, 5, and 10), and Region 3 (VISNs 11, 12, 15, and 23) and Primeaux Health Strategies, LLC (Primeaux) was awarded two contracts<sup>3</sup> for Region 2 (VISNs 6, 7, 8, and 9) and Region 4 (VISNs 16, 17, and 18).<sup>4</sup> In April 2009, ETS acquired Primeaux and became responsible for the two contracts awarded to Primeaux. ETS did provide a novation agreement executed with the Secretary of State of Louisiana to the Contracting Officer (CO); however, ETS did not request a novation with VA and continued to operate under the Primeaux name. All five contracts included a contract clause and FAR clauses limiting subcontracting. Paragraph 10 of the statement of work states:

**Subcontractor Requirements:** If a subcontractor is used to complete the requirements of the contractor, the contractor shall provide that information in their proposal. The prime contractor shall conduct a minimum of 51% of the requirements of the contract.

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<sup>1</sup> Under the VA's Fee Basis Program, eligible veterans may obtain health care services in the private sector. The Program provides coverage for inpatient care, outpatient care, ambulatory surgery, dental services, and related professional and ancillary services.

<sup>2</sup> ETS was awarded contract VA741-P-0011 for Region 5 on September 26, 2007; contract VA741-P-0026 for Region 1 on September 9, 2008; and contract VA741-P-0027 for Region 3 on September 9, 2008.

<sup>3</sup> Primeaux was awarded contract VA741-P-0028 for Region 2 on September 17, 2008 and contract VA741-P-0030 for Region 4 on September 24, 2008.

<sup>4</sup> These contracts were awarded for a base year plus four option years.

The contracts also included FAR clauses 52.219-14, Limitations on Subcontracting and 52.219-27, Notice of Service-Disabled Veteran-Owned Small Business Set-Aside. FAR Clause 52.219-14 states:

(c) By submission of an offer and execution of a contract, the Offeror/Contractor agrees that in performance of the contract in the case of a contract for—

(1) *Services (except construction)*. At least 50 percent of the cost of contract performance incurred for personnel shall be expended for employees of the concern.

FAR Clause 52.219-27 states:

(d) *Agreement*. A service-disabled veteran-owned small business concern agrees that in performance of this contract, in the case of a contract for—

(1) *Services (except construction)*, at least 50 percent of the cost of personnel for contract performance will be spent for employees of the concern or employees of other service-disabled veteran-owned small business concerns.

For these contracts, VA assigned the North American Industry Classification System (NAICS) code of 524291 (Claims Adjusting). The size limitation established by the Small Business Administration (SBA) for this NAICS code is \$7 million in annual revenue. To be eligible for award as an SDVOSB, an offeror must represent in good faith that it is an SDVOSB at the time of its written representation. After the contract was awarded, the contractor must continue to represent that it is compliant with the size limitations established by the SBA for the assigned NAICS code.

Both ETS and Primeaux used Health Net as their subcontractor. Health Net has a network of health care providers and provides claims re-pricing services. The contracts required the contractor to identify potential cost savings by comparing claims that VA received from non-VA health care providers for services for veterans to rates established by the contractor if the provider was part of their network. If the network rates established between the contractor and the provider were lower than the VA-allowable amounts, the difference between the two amounts was considered a potential savings to VA and the contractors received a percentage of the potential savings as the agreed upon fee. Exhibit A shows the claims re-pricing process graphically. The fee percentages ranged from 13.5 to 16 percent plus 5 percent for performance incentives. ETS reported their total contract fee was \$82 million for all five contracts for the period of January 2009 to December 2011.

The fee that VA paid to ETS is determined and based strictly on the percentage of the difference between the VA-allowable amount and the reported network rate with that

provider and not based on any actual savings realized by VA. In other words, the fee is not based on any recovery by VA or future savings due to adjustments in the amounts claimed by the provider. (See Exhibit B for FY 2011 contractor's fee data as an example.)

Records show that VA had a contractual relationship with Health Net for claims re-pricing beginning in 1999 shortly after regulations were promulgated establishing fees that VA would pay for services provided by non-VA hospitals and physicians. Regulations promulgated at 38 Code of Federal Regulations (CFR) § 17.56 in July 1998, provided that payment for non-VA physician services associated with outpatient and inpatient care provided at non-VA facilities would be the "lesser of the amount billed or the amount calculated using the formula developed by the Department of Health & Human Services, Health Care Financing Administration (HCFA) under Medicare's participating fees schedule for the period on which the service is provided." The regulation also provided that if no amount has been calculated under Medicare's participating physician fee program or the services constituted anesthesia services, the payment would be the "lesser of the actual amount billed or the amount calculated using the 75<sup>th</sup> percentile methodology set forth in paragraph (c) of the regulation; or the usual and customary rate if there were fewer than eight treatment occurrences for a procedure during the previous fiscal year." This regulation was amended in November 2000 to allow payment at rates negotiated between VA and hospitals or physicians. It is clear from the information published in the Federal Register, that payment at other than Medicare rates was to be the exception rather than the rule. The regulations did not provide for a re-pricing agent or re-pricing services such as those provided by Health Net and subsequently ETS and Primeaux. Therefore, it is not clear what, if any, benefit VA derived for these services prior to February 2010.

In February 2010, VA issued a proposed rule to amend §17.56. The rule became final in December 2010. The new regulations provided the following payment methodology hierarchy:

- (a) (1) If a specific amount has been negotiated with a specific provider, VA will pay that amount.
- (2) If an amount has not been negotiated under paragraph (a)(1) of this section, VA will pay the lowest of the following amounts:
  - (i) The applicable Medicare fee schedule or prospective payment system amount (Medicare rate) for the period in which the service was provided. . . .
  - (ii) The amount negotiated by a repricing agent if the provider is participating within the repricing agent's network and VA has a contract with that repricing agent. For the purposes of this section, *repricing agent* means a contractor that seeks to connect VA with discounted rates from non-VA providers as a result of existing

contracts that the non-VA provider may have within the commercial health care industry.

(iii) The amount that the provider bills the general public for the same service.

Although an amount negotiated by a re-pricing agent, such as Health Net, was an option after the regulations were amended, this amount could only be used if:

- a specific amount has not been negotiated with a specific provider under paragraph (a)(1) of 38 CFR § 17.56;
- VA has a contract with the re-pricing contractor;
- the provider is participating within the re-pricing agent's network; and
- the re-priced amount is the lowest in the payment methodology hierarchy under paragraph (a)(2) of 38 CFR § 17.56.

In 2010, the contracts awarded in 2007 and 2008 to ETS and Primeaux were still in effect. The contracts should have been terminated because the regulation defines a re-pricing agent as a "contractor that seeks to connect VA with discounted rates from non-VA providers as a result of existing contracts that the non-VA provider may have within the commercial health care industry" (emphasis added). Neither ETS nor Primeaux qualify as re-pricing agents under this definition.

Although the percentage fee to ETS was not based on actual savings, we attempted to determine whether HAC used the information provided under the contract to obtain cost savings. However, we were unable to identify any actual savings. The current COTR at the HAC did not have information on whether the potential savings were actually realized for each VA Medical Center (VAMC) because each one was responsible for submitting claims to Health Net and paying for the services. Each VAMC prepared a purchase order generally once a year using its respective contract, obligated funds for re-pricing services, and made payments to ETS. To validate any actual savings from claims re-pricing, we visited a local fee service office, but we could not substantiate actual savings. We were provided data that showed payment to non-VA providers at the price provided VA by Health Net; however, the data also indicated that the Health Net prices were significantly higher than the Medicare rates. According to the provisions in 38 CFR §17.56, after 2010, payment should have been at the Medicare rate because it was lower. Prior to 2010, there was no provision to use re-pricing data to establish reimbursement rates for non-VA care.

## Scope and Methodology

For our review, we interviewed VA and contractors' personnel for issues relevant to the review objectives; and obtained, reviewed, and analyzed the following information and data:

- Five claims re-pricing contracts
- ETS's fee data reported to VA; financial records relevant to the review objectives; and payment data to its employees and subcontractors
- Contractors' status data reported in the Online Representations and Certifications Application (ORCA)

We used the following guidance applicable to the review objectives:

- Subcontractor Requirements prescribed in the five claims re-pricing contracts
- FAR Subpart 4.12, Representations and Certifications
- FAR Subpart 19.3, Determination of Small Business Status for Small Business Programs
- FAR Subpart 19.14, Service-Disabled Veteran-Owned Small Business Procurement Program
- FAR Subpart 52.219-14, Limitations on Subcontracting
- FAR Subpart 52.219-27, Notice of Total Service-Disabled Veteran-Owned Small Business Set-Aside
- VAAR Subpart 852.219-10, VA Notice of Total Service-Disabled Veteran-Owned Small Business Set-Aside
- VAAR Subpart 809.4, Debarment, Suspension, and Ineligibility
- VAAR Part 849, Termination of Contracts
- Title 31, U.S.C. § 1352, Limitation on Use of Appropriated Funds to Influence Certain Federal Contracting and Financial Transactions
- Public Law 109-461, Title V, § 502, Paragraph 8127(g), Enforcement Penalties for Misrepresentation
- Small Business Administration (SBA) "Table of Small Business Size Standards Matched to North American Industry Classification System Codes"
- 38 CFR § 17.56, Payment for non-VA physician and other health care professional services, (2007 to 2010 Editions)
- 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, (7-1-2011 Edition)

## Results of Review

### **Finding 1: ETS Did Not Comply with Subcontracting Limitations.**

All five contract awards for claims re-pricing were SDVOSB set-aside procurements. As such, all five contracts had subcontracting limitations contained in the contract that limited how much ETS could outsource to subcontractors. Our review determined that ETS did not have the ability to re-price claims and, notwithstanding the provisions in the contract limiting subcontracting, always intended to subcontract the total contract requirements to Health Net. Also, our review of ETS's financial information demonstrates that the majority of contract revenues ultimately went to its subcontractor, Health Net.

**1. ETS Intended for Health Net to Perform All Claims Re-pricing.** In 1999, Health Net approached VA with a concept of Preferred Pricing for claims generated from non-VA health care providers, which is also known as claims re-pricing. In August 1999 VA awarded its first VISN level contract in Northern California to Health Net for claims re-pricing. In 2006, the HAC planned to centralize and consolidate the VISN level re-pricing contracts to five regions. Our review of early planning documents found that VA originally intended a full and open competition acquisition. Based on an interview with the ETS Program Manager we learned that during this same time frame, Health Net encouraged Mr. Donald Neilson, a former VA senior official, to set up an SDVOSB concern for claims re-pricing contracts. According to ETS's history on its website, Mr. Neilson established the business in October 2006.

Based on documents obtained from the VA Contracting Specialist (CS), we determined that during February 2006, HAC officials discussed the then-future contract information with Health Net. One official at the HAC stated in an e-mail with the subject line "national re-pricing agreement:"

I'm not aware of any major changes regarding the technical requirements, but if there are any we just need to get them into a new draft SOW.... Attached for your info [*sic*] only at the moment is the latest version of my proposed letter to Health Net..., assuming there isn't a hard push-back from Health Net.... Also, we will need to be thinking about how we want Health Net reports to be re-worded going forward. The visit from Frank Kelly in a couple weeks may be a good forum to start discussing that.

Mr. Frank Kelly was Health Net's Director of VA Programs in 2006 and the e-mail clearly shows that VA was including Health Net in discussions regarding the statement of work and how Health Net reports should be re-worded under the new national agreements. In March 2008, Mr. Kelly left Health Net to establish Primeaux, which was the SDVOSB that received two of the claims re-pricing contracts in September 2008.

The data shows, when taken in its entirety, that ETS and Primeaux were set up to obtain SDVOSB set-aside contracts for claims re-pricing with the intention to subcontract most, if not all, of the requirements to Health Net. Once VA awarded the contracts to ETS and Primeaux, Health Net performed 100 percent of the claims re-pricing work for ETS. Health Net performed more than 80 percent of the claims reprocessing for Primeaux until ETS acquired it in April 2009 after which time Health Net performed 100 percent of the work. ETS and Primeaux were merely SDVOSB pass-throughs.

We determined that ETS did not comply with the contract provision and FAR clauses on subcontracting limitations:

ETS Did Not Perform, Did Not Intend to Perform, and Was Not Capable of Performing Any of the Required Tasks. All five re-pricing contracts contained a contract clause (statement of work paragraph 10) stating, “If a subcontractor is used to complete the requirements of the contractor, the contractor shall provide that information in their proposal. **The prime contractor shall conduct a minimum of 51% of the requirements of the contract.**” ETS did not perform any work under the contracts, much less a minimum of 51 percent of the tasks required by the contracts. An ETS official admitted to us that ETS did not perform any of the claims re-pricing. In fact, ETS never actually received or reviewed claims from VA that were to be re-priced. Notwithstanding the fact that the contracts were awarded to ETS and Primeaux as SDVOSB set-asides and included requirements that ETS and Primeaux perform a percentage of the work, VHA sent all claims directly to Health Net, not ETS or Primeaux. These actions by VHA officials shows that HAC intentionally misused the SDVOSB set-aside authority to ensure that Health Net would provide the required services, which otherwise may not have been possible if Health Net had to compete for the award.

Based on ETS’s profit/loss (P/L) statements for calendar years (CY) 2009, 2010, and 2011, Health Net was the only subcontractor who performed re-pricing of claims for ETS under the five contracts (see Exhibit A). We found that ETS paid Health Net 79 percent of its contract revenue in 2009, 62 percent in 2010, and 53 percent in 2011. Conversely, ETS kept 14 to 25 percent of its entire contract revenues. In addition to further demonstrating that Health Net was performing the actual work under the re-pricing contracts, this information also indicates that VHA was overpaying for the services as ETS and Primeaux were paid a significant fee just for using their SDVOSB status to obtain the contract awards on behalf of Health Net. In addition, the figures show that VHA paid millions of dollars without any evidence of cost savings, recovery, or avoidance.

ETS Did Not Expend 50 Percent of The Personnel Cost On Their Own Employees. All five contracts contained FAR Subparts 52.219-14 and 52.219-17 that require the prime contractor to expend at least 50 percent of the cost of personnel for contract performance on their own or another SDVOSB's employees. We determined that ETS did not comply with requirements of these FAR clauses. We compared the ETS personnel costs to the total payments made to Health Net, a large business, which actually conducted the claims re-pricing for ETS. Using the data in the ETS's P/L statements, we determined that ETS's personnel costs ranged from 0.92 to 3.74 percent compared to the payments made to Health Net. Conversely, ETS paid Health Net 96 to 98 percent of the cost for contract performance, which is claims re-pricing.

**2. ETS Misrepresented Its Capability to Perform Tasks Under NAICS Code 524291.** Contractors are required to annually certify their status and applicable NAICS codes in ORCA. FAR Subparts 19.1403(b)(2) and 19.301-2(c) require that at the time an SDVOSB submits its offer, it must represent to the CO that it is a small business concern under the NAICS code specifically assigned to the acquisition. We determined that ETS misrepresented that they were a small business concern relative to the NAICS code assigned to these contracts. ETS did not have the ability to re-price the contracts as they had neither the systems, expertise, nor the network of providers necessary to re-price the claims; and intended to subcontract all the requirements to Health Net. Table 1 shows ETS certified they were an SDVOSB capable of performing work related to NAICS code 524291 from October 2007 to January 2011. For the period from January 26, 2011, to January 26, 2012, ETS did not use the NAICS code of 524291, which means ETS no longer meets the small business size standard, corresponding to the NAICS code assigned to the five contracts, in effect at the time of contract award.

**Table 1—ORCA Certification of NAICS Code 524291**

<b>Certification Period in ORCA</b>	<b>NAICS Code 524291 Used</b>
10/04/2007-08/18/2008	Yes
08/18/2008-08/12/2009	Yes
08/12/2009-12/03/2009	Yes
02/09/2010-01/26/2011	Yes
01/26/2011-01/26/2012	No

According to FAR 4.1201, submission of the certification and disclosure of a company is a prerequisite for entering into a contract with a Federal Government entity. By certifying that they had the ability to perform work related to NAICS code 524291, ETS misrepresented its status in order to qualify for SDVOSB set-aside contracts for claims re-pricing.

## **Finding 2: The SDVOSB Set-aside Determination Was Not Properly Justified**

HAC personnel did not properly justify the SDVOSB set-aside procurements. FAR Subpart 19.1202-2 requires that the extent of participation of SDVOSB concerns in performance of the contract for the assigned NAICS code be evaluated in competitive, negotiated acquisitions expected to exceed \$650,000. That is, VA should determine that SDVOSB concerns are capable of satisfying the contract requirements in terms of the NAICS code assigned to the contract when the receipt amount by the potential contractor exceeds \$650,000. Each of the five contracts listed \$6.5 million<sup>5</sup> as the maximum receipt amount by the potential contractor for the assigned NAICS code 524291, which is for claims adjusting primarily in investigating, appraising, and settling insurance claims.

Of the five contracts, we selected the contract VA741-P-0011 awarded on September 26, 2007, for a detailed review of the acquisition plan and source selection documents. Based on the acquisition plan, HAC personnel initially planned to solicit offers through an unrestricted, full and open competition because prior VISN competitions and an informal market survey did not support a set-aside acquisition. The documentation shows that HAC officials changed the acquisition from full and open competition to an SDVOSB set-aside procurement. Our review of the contract file found that it lacked documentation providing insight as to the reason for the change in the type of acquisition. As stated earlier in this report, we know VA officials at the HAC were discussing the national re-pricing effort with Health Net officials who at the same time were encouraging a VA former employee to start up an SDVOSB company. HAC officials also stated that they became aware of other SDVOSB companies that were identified in a local claims re-pricing contract solicitation that was conducted as an SDVOSB set-aside procurement in VISN 10/11. The CS for VISN 10/11 stated that there were five offers from SDVOSBs (one of them being ETS) in response to the VISN 10/11 solicitation. The CS stated that ETS received the highest ranking and the remaining four contractors finished at a distance. Based on this information, the CO stated that they decided at that time to award the contract, VA741-P-0011, and subsequently process all five national re-pricing procurements as SDVOSB set-asides. However, there is no documentation supporting the statements that there were five potential SDVOSBs; there is no evidence that VA issued a sources sought notice to determine if there were two or more SDVOSBs capable of performing the work; and there is no support that shows that VA attempted any technical evaluation of ETS's performance under the VISN 10/11 contract. Upon posting of the solicitation for contract VA741-P-0011 on the Federal Business Opportunities website, the CO received one proposal from ETS and denied another company that requested an extension.

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<sup>5</sup> The contracts included the small business size limitation of \$6.5 million for NAICS code 524291.

Contract VA741-P-0011 was the first claims re-pricing contract awarded by the HAC in September 2007 and it was signed by the initial CO. In August 2008 a new CO at the HAC was assigned the remaining four procurement actions and was told that they were complete and ready to be awarded. The new CO stated that his only involvement in the procurement process was to award the contracts and administer them.

We briefly reviewed documents contained in eCMS (VA's electronic contract management system) for the four remaining contracts and did not find any evidence of additional market research in these four procurements. We did observe documentation for one of the contracts where the Contracting Officer's Technical Representative (COTR) doubted whether one of the SDVOSB concerns could actually perform 50 percent of the work (this SDVOSB was not selected). However, this same concern did not appear to be raised in reference to ETS or Primeaux. Documents also show that after award to ETS and Primeaux, facilities would continue to send claims directly to Health Net—nothing had changed except for the invoicing.

After VHA awarded the contracts to ETS and Primeaux in 2007 and 2008, the COTR learned that Health Net was performing the majority, if not all, of the re-pricing work on behalf of both ETS and Primeaux. In December 2008, the COTR raised a concern to the CO that Primeaux and ETS potentially violated the SDVOSB requirement prescribed in FAR 52.219-27(c)(1). On January 8, 2009, the CO requested ETS and Primeaux to self-certify the percentage of the contractor's personnel cost incurred for the performance of all five contracts. On January 21, 2009, ETS President, Mr. Neilson, submitted a memorandum stating, "ETS provides approximately 62 percent of the cost of personnel for contract performance as required by FAR 52.219-27(c)(1)."

In response, the COTR documented her concern that ETS employed six individuals, did not identify all of its subcontractors in its proposal, and suggested that they may have misinterpreted the request by the CO. According to the COTR's document, in January 2009, the CO conducted numerous discussions with VA's Office of Small and Disadvantaged Business Utilization concerning appropriate actions and guidance but does not indicate what advice or guidance was given. The COTR documented on January 27, 2009, that the President of Primeaux stated, "12.9 percent of the contract revenue was retained" by Primeaux for the contract performance, including employee compensation. This low percentage showed Primeaux was in clear violation of the restrictions on subcontracting. According to the COTR, there was a telephone conversation held with Primeaux on January 28, 2009, and it included the Chief Business Office (CBO) Chief of Logistics, CBO Deputy Chief of Logistics, CO, and COTR. However, the COTR did not document the details of the conversation and there is no evidence that any action was taken to ensure compliance or terminate the contract for default. Shortly thereafter, in April 2009, ETS acquired Primeaux and became the prime contractor for the two contracts awarded to Primeaux. However, ETS did not request a novation and instead, retained the company's name (Primeaux), which was inappropriate.

Our review found that the statements made by ETS and Primeaux in response to the CO's request for verification of compliance with the applicable contract provisions were false and misleading.

### Additional Issue

During our review we attempted to determine if VA actually received any cost savings as a result of the re-pricing work by ETS. As stated earlier, the COTR had no information whether the potential savings identified by ETS were actually realized by VA. We visited the fee office in Perry Point, MD and reviewed selected individual claims to determine if VA realized any savings due to the ETS re-pricing. Under the current regulations, when no contract is present with the provider, VA pays the lower of the Medicare rate, the rate from the re-pricer (Health Net), or billed charges. The only time VA would recognize savings by a re-pricer like Health Net would be when their rate is lower than the Medicare or actual billed rate. Our review of fee claims for four patients for a one month period at Perry Point, MD found no instances where ETS’s rate was less than the Medicare rate; in fact, it was substantially higher than the Medicare rate as shown in Table 2.

**Table 2—Comparison of ETS Re-priced Amounts vs. Medicare Amount for Perry Point, MD Fee Claims**

Patient #	Period of Service	ETS Re-priced Amount (b)	Medicare Amount (a)	Difference (b) - (a)
1	April 2009	\$26,941.14	\$4,832.43	\$22,108.71
2	March 2009	59,493.80	10,648.97	48,844.83
3	April 2009	60,306.61	10,802.63	49,503.98
4	April 2009	36,316.37	9,358.95	26,957.42
	Total	\$183,057.92	\$35,642.98	\$147,414.94

The OIG, Office of Healthcare Inspections (OHI), identified overpayments of non-VA care claims as part of their on-going reviews of Community Based Outpatient Clinics (CBOC). OHI conducted a preliminary review of fee claims for non-VA care for three CBOCs for the period of February 15, 2011, through September 30, 2011. Their review was limited to CT, MRI, and PET scans. OHI found that VA overpaid at rates significantly above Medicare rates when the amount submitted by the re-pricer was used as shown in Table 3 on the next page.

**Table 3—Comparison of VA Payments vs. Medicare Amounts for Three CBOCs**

<b>CBOC</b>	<b>Actual VA Payments</b>	<b>Amounts per Medicare</b>	<b>Overpayment</b>	<b>Overpayment Rate</b>
Payson, AZ	\$32,479	\$11,310	\$21,169	187%
ShowLow, AZ	174,024	77,441	96,583	125%
Savannah, GA	17,786	8,414	9,372	111%
Totals	\$224,289	\$97,165	\$127,124	131%

OHI determined that the majority of the overpayments was due to the fact that the local fee offices were not submitting the claims to Affiliated Computer Services, Inc. (ACS), VA’s Medicare pricer. We saw no circumstance where the Health Net re-pricer amount was lower than Medicare.

Under the new regulations, VA must determine which of three prices is the lowest. To do so, VA must pay both a Medicare pricer and a re-pricer to make this determination. As discussed above the fees for the re-pricer are significant since they are based on a percentage of potential cost savings, not savings actually realized. In other words, we pay a percentage of the cost savings, even if the amount submitted by the re-pricer is not lower than Medicare. However, at the same time VA would have to pay the Medicare pricer the contract fee of almost \$2.00 per claim. Unless there is evidence that the amounts submitted by the re-pricer are lower than the rate paid by Medicare in amounts significant enough to justify the paying fees to the re-pricer, we recommend not using a re-pricer or limiting the re-pricer to those procedures for which there is no Medicare rate or for which VA is certain the re-pricer amount would be less than the Medicare rates established by the Centers for Medicare and Medicaid Services (CMS).

## Conclusions

Our review determined that ETS did not comply with the contract provisions limiting subcontracting. ETS did not perform any of the re-pricing tasks under its five contracts nor did ETS have the capability to perform the tasks required under the contract even though ETS officials certified in the ORCA system that it was qualified to perform tasks related to the NAICS code 524291, Claims Adjusting. Health Net encouraged the president of ETS to establish ETS as an SDVOSB concern in order to compete for SDVOSB set-asides with the intention that Health Net would perform all the requirements under the contract. ETS simply acted as an SDVOSB front for Health Net and funneled all the work and the majority of contract revenues to Health Net.

Our review of the acquisition planning documents shows that HAC officials did not properly justify the SDVOSB set-asides for the claims re-pricing contracts. HAC personnel changed the initial acquisition method of an unrestricted full and open competition to a total set-aside acquisition for SDVOSB without adequate market research or proper justification or support to show that two or more qualified SDVOSB concerns existed that could perform the work associated with the NAICS code assigned to the procurements.

We also determined that the revised regulations allow for VA to use the amount submitted by a re-pricer if the amount is lower than the Medicare rate established by CMS. Our review and work done by OHI did not show that the amounts submitted by the re-pricer were lower than the established Medicare rates; therefore, we question whether it is fiscally sound to pay for both a Medicare pricer and a re-pricer to review each claim for VA to determine which is lower. This is especially true given the significant fees paid to the re-pricer regardless of whether there is a cost savings.

## Recommendations

We recommend that the Chief Procurement and Logistics Officer:

1. Terminate the five claims re-pricing contracts for default based on breach of contract in accordance with FAR Subpart 49.4 and VAAR Part 849.
2. Coordinate with the Under Secretary for Health to determine if there is a need for any contract(s) for repricing of non-VA fee claims.
3. If the vendor is a former VA employee or primarily composed of former VA employees; ensure that the requirements do not preclude competition by giving former VA employees an unfair advantage.

We recommend that the Under Secretary for Health:

4. Determine whether claims re-pricing provides access to prices lower than Medicare prices for non-VA fee based care and whether there has been actual cost savings. Evaluate whether these contracts are necessary and are in the best interest of the taxpayer taking into consideration the fact that VA must pay to have each claim reviewed by a Medicare pricer and the re-pricer to determine which is lower.
5. Ensure *all* fee claims are forwarded to ACS, VA's Medicare pricer, to determine the Medicare rates.
6. Implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition or give former VA employees an unfair advantage.
7. Ensure justifications for sole-source awards receive appropriate approvals to ensure that competition is achieved to the maximum extent practicable.

## Acronyms

ACS	Affiliated Computer Services, Inc.
CBOC	Community Based Outpatient Clinic
CMS	Centers for Medicare and Medicaid Services
CO	Contracting Officer
COTR	Contracting Officer's Technical Representative
CS	Contract Specialist
CY	Calendar Year
eCMS	Electronic Contract Management System
ETS	Enterprise Technology Solutions, LLC
FAR	Federal Acquisition Regulation
FBCS	Fee Basis Claims System
FY	Fiscal Year
HAC	Health Administration Center
IRS	Internal Revenue Service
NAICS	North American Industry Classification System Code
OHI	Office of Healthcare Inspections
OIG	Office of Inspector General
ORCA	Online Representations and Certifications Application
P/L	Profit/Loss
SBA	Small Business Administration
SDVOSB	Service-Disabled Veteran-Owned Small Business
VA	Department of Veterans Affairs
VAAR	VA Acquisition Regulation
VAMC	VA Medical Center
VISN	Veterans Integrated Service Networks

**Exhibit A, Claims Re-pricing Process**  
**Page 1 of 2**

## **Overview**

### **Claims Information Flow**

One of the benefits of the Preferred Pricing Program is that **claims information flow** is completely invisible to the veteran. In fact, there is only a small operational impact on the VAMC during this **five-step process**, which we describe below and visually depict in Exhibit 1, The Claims Flow Process.

**Step 1:** The process begins when the veteran seeks care from a medical provider. The provider treats the veteran and sends a claim to the VA business office as usual.

**Step 2:** When the VA receives the claim, staff confirms that the patient is indeed an eligible veteran and that the services rendered are a covered benefit. The claim is entered into the VA's fee system and the VA allowed amount is determined.

This VA allowed amount could be based on either the VA fee schedule (which is the Resource Based Relative Value Scale or RBRVS), or the VISTA Diagnosis Related Group (DRG) amount or a Per Diem. It is very important that the VAMC indicate how much the VA allowed amount is on every claim [even if the VAMC is going to pay the billed charges.]

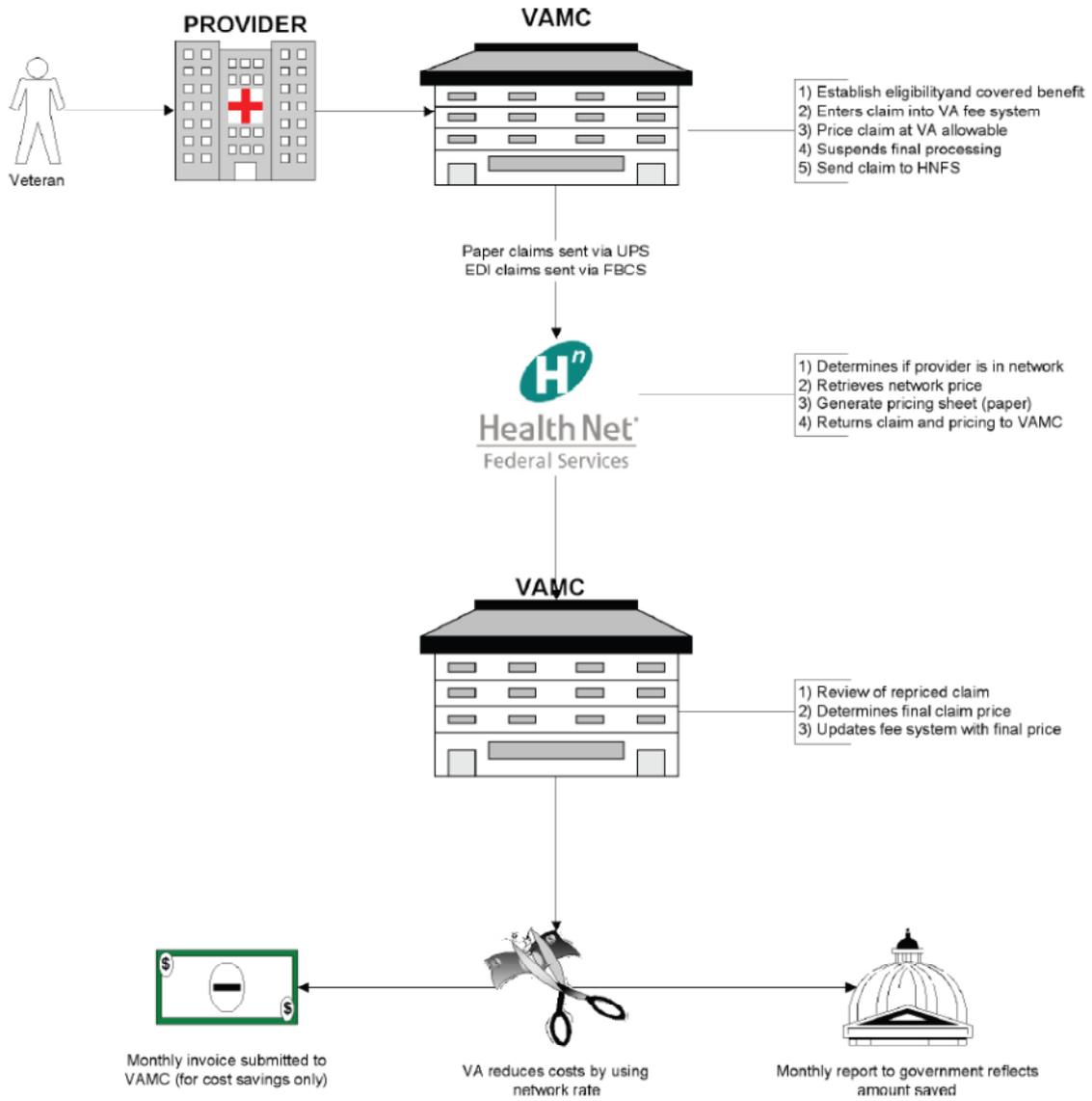
**Step 3:** The VAMC then selects those claims that are to be priced by Health Net, and pends final processing of those claims before payment is made.

- Paper claims are photocopied and collected in batches and sent to Health Net's claims repricer via UPS overnight delivery.
- Electronic claims are entered into the Fee Basis Claims System (FBCS) and submitted through that system.

**Step 4:** Health Net's claims repricer then examines each claim and applies network rates when the claim is from a network provider. Health Net returns the claim, showing the network rate on the Pricing Sheet to the VAMC.

**Step 5:** Once received at the VAMC, Health Net's network price is compared against the VA's allowed amount—based on this evaluation, the VA determines the final claim price.

**Exhibit A, Claims Re-pricing Process**  
**Page 2 of 2**



**Exhibit B, FY 2011 ETS Contract Fees**

**FY 2011 Contractor's Fee Reported to VA**

VISN #	VA-allowable Amount	Health Net Re-priced Amount	"Savings" Reported to VA (See Note 1.)	"Contractor's Fee" Reported to VA	Fee % (See Note 2.)
VISN 1	\$65,456,883.50	\$60,813,296.98	\$4,643,586.52	\$836,597.39	18.02%
VISN 2	\$25,518,787.98	\$23,883,565.12	\$1,635,222.86	\$303,374.46	18.55%
VISN 3	\$12,274,683.40	\$11,758,991.53	\$515,691.87	\$92,912.68	18.02%
VISN 4	\$101,111,517.39	\$90,976,573.42	\$10,134,943.97	\$1,776,211.80	17.53%
VISN 5	\$23,334,804.62	\$20,294,624.53	\$3,040,180.09	\$535,166.91	17.60%
VISN 6	\$103,891,364.75	\$98,996,939.14	\$4,892,839.09	\$1,003,032.03	20.50%
VISN 7	\$183,413,564.97	\$159,932,583.79	\$23,480,981.18	\$4,096,719.46	17.45%
VISN 8	\$162,226,510.74	\$146,109,015.19	\$16,117,495.55	\$2,780,847.89	17.25%
VISN 9	\$86,585,138.87	\$80,430,946.07	\$6,154,192.80	\$1,078,788.21	17.53%
VISN 10	\$77,784,267.08	\$72,197,093.33	\$5,587,173.75	\$993,013.66	17.77%
VISN 11	\$71,245,857.51	\$65,437,655.12	\$5,808,202.39	\$1,048,334.98	18.05%
VISN 12	\$39,106,546.75	\$36,472,793.08	\$2,633,753.67	\$480,821.12	18.26%
VISN 15	\$139,072,992.48	\$124,613,621.27	\$14,459,371.21	\$2,629,005.73	18.18%
VISN 16	\$154,958,908.52	\$138,265,187.27	\$16,693,721.25	\$3,088,338.37	18.50%
VISN 17	\$126,694,815.67	\$101,973,664.17	\$24,721,151.50	\$4,436,403.90	17.95%
VISN 18	\$129,599,889.29	\$118,998,665.89	\$10,601,223.40	\$1,920,752.94	18.12%
VISN 19	\$64,513,971.17	\$60,744,801.95	\$3,769,169.22	\$714,126.40	18.95%
VISN 20	\$118,289,182.79	\$112,839,139.38	\$5,450,043.41	\$1,008,731.81	18.51%
VISN 21	\$109,808,804.76	\$98,070,519.19	\$11,738,285.57	\$2,131,073.08	18.15%
VISN 22	\$88,528,132.61	\$78,599,087.73	\$9,929,044.88	\$1,824,678.53	18.38%
VISN 23	\$143,351,621.61	\$134,947,113.98	\$8,404,507.63	\$1,531,717.19	18.22%
<b>TOTAL:</b>	<b>\$2,026,768,246.46</b>	<b>\$1,836,355,878.13</b>	<b>\$190,410,781.81</b>	<b>\$34,310,648.54</b>	<b>18.02%</b>

**Notes**

1. The reported "Savings" were potential ones and not realized ones.
2. VAOIG calculated the fee percentages, but ETS reported to VA the rest of the data on this Exhibit B.

## Management Comments

**Department of  
Veterans Affairs**

## Memorandum

Date: **AUG 08 2012**

From: Under Secretary for Health (10)

Subj: Office of Inspector General, Office of Contract Review, Review of Enterprise Technology Solutions, LLC., Compliance with Service-Disabled, Veteran Owned, Small Business Program Subcontracting Limitations (VAIQ 7243742)

To: Director, Healthcare Resources Division, Office of Contract Review (55)

1. I have reviewed the draft report and concur with all seven of the report's recommendations. Attached is the action plan that addresses the recommendations.
2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10AR) at (202) 461-7014.



Robert A. Petzel, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION  
Action Plan**

**OIG Draft Report, Review of Enterprise Technology Solutions, LLC., Compliance with Service-Disabled Veteran-Owned Small Business Program Subcontracting Limitations (VAIQ 7243742)**

**Date of Draft Report: July 5, 2012**

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<b>Recommendations/ Actions</b>	<b>Status</b>	<b>Completion Date</b>
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**Recommendation 1: We recommend that the Chief Procurement and Logistics Officer terminate the five claims re-pricing contracts for default based on breach of contract in accordance with FAR Subpart 49.4 and VAAR Part 849.**

VHA Comments  
Concur

Pursuant to the Federal Acquisition Regulations (FAR), Subpart 49.4 and Veterans Affairs Acquisition Regulations (VAAR), Part 849, the Veterans Health Administration (VHA) Chief Procurement and Logistics Officer (CP&LO) intends to terminate for default all five contracts for claims re-pricing. Upon termination of the contracts, VHA's Chief Business Office (CBO) will take the following actions:

1. Notify field sites to immediately stop transmitting claims to Enterprise Technology Solutions (ETS) for re-pricing.
2. Initiate an information technology (IT) solution to disable the Fee Basis Claims System (FBCS) functionality to transmit claims to ETS.

In process

October 31, 2012

**Recommendation 2: We recommend that the Chief Procurement and Logistics Officer coordinate with the Under Secretary for Health to determine if there is a need for any contract(s) for repricing of non-VA fee claims.**

VHA Comments

Concur

VHA's CBO will work with CP&LO to take steps to determine the availability of repricing contract opportunities that would be beneficial to the Department of Veterans Affairs (VA). This would include taking steps to do a Request for Information to see if savings below Centers for Medicare & Medicaid Services (CMS) rates are available.

In process

October 31, 2012

**Recommendation 3: We recommend that the Chief Procurement and Logistics Officer if the vendor is a former VA employee or primarily composed of former VA employees; ensure that the requirements do not preclude competition by giving former VA employees an unfair advantage.**

VHA Comments

Concur

VHA CP&LO will review and integrate into the existing customer checklists for Services and Advisory and Assistance requirements that the customer must provide a statement notifying the Contracting Officer (CO) if the proposed or potential vendor is a former VA employee, or if the staff of the vendor is primarily composed of former VA staff. VHA CP&LO will also prepare a memorandum to the procurement staff to remind them to carefully review requirement documentation to ensure documents do not contain restrictive language that would inhibit competition.

In process

October 31, 2012

**Recommendation 4:** We recommend that the Under Secretary for Health, determine whether claims re-pricing provides access to prices lower than Medicare prices for non-VA fee based care and whether there has been actual cost savings. Evaluate whether these contracts are necessary and are in the best interest of the taxpayer taking into consideration the fact that VA must pay to have each claim reviewed by a Medicare pricer and the re-pricer to determine which is lower.

VHA Comments

Concur

VHA's CBO will conduct analysis to determine if re-pricing did provide prices lower than Medicare rates and if there have been actual cost savings. This will be done by auditing what the Medicare price would be, re-pricing amount, and amount paid.

Additionally, CBO will perform a cost benefit ratio in order to determine if continued use of re-pricing continues to be beneficial with the use of Medicare rates.

In process

October 31, 2012

**Recommendation 5:** We recommend that the Under Secretary for Health, ensure all fee claims are forwarded to AC, VA's Medicare pricer, to determine the Medicare rates.

VHA Response

Concur

While VHA agrees with the intent of this statement which is to ensure that VHA pays CMS pricing as extensively as possible, the requirement to pay a Medicare pricing contractor is becoming obsolete because of a technical upgrade to the FBCS software that allows sites to process claims at Medicare rates. Currently, the Medicare pricing contractor, ACS, prices the following claims for the Non-VA Care Program: Ambulatory Surgical Center, Anesthesia, Dialysis, and Hospital Outpatient. Until the FBCS software upgrade is complete at a site, VHA expects

sites to continue submitting these claims to the Medicare pricing contractor. The FBCS upgrade is scheduled for completion in August 2012.

In process

August 31, 2012

**Recommendation 6. We recommend that the Under Secretary for Health implement mandatory training requirements for program offices to ensure requirements are not written to preclude competition or give former VA employees an unfair advantage.**

VHA Response

Concur

In fiscal year (FY) 2013, the Deputy Under Secretary for Health for Operations and Management will mandate that identified program office officials and Contracting Officer Representatives will complete a performance-based statement of work course to ensure that requirements are not written to preclude competition or give former VA employees an unfair advantage.

In process

September 30, 2013

**Recommendation 7. We recommend that the Under Secretary for Health ensure justifications for sole-source awards receive appropriate approvals to ensure that competition is achieved to the maximum extent practicable.**

VHA Response

Concur

VHA CP&LO developed and implemented an Other Than Full and Open Competition standard operating procedure (dated March 22, 2011) to address appropriate review and approval of sole source awards. Current approval thresholds require Network/Program Contract Manager approval for proposed sole source contracts estimated at \$3,000 to \$500,000. Contracts over \$500,000 require approval from the Head of the Contracting Activity.

In FY 2011 and FY 2012, VHA CP&LO also instituted metrics to track the number and dollar value of sole source awards issued by each VHA contracting office.

Complete

Veterans Health Administration  
August 2012

**Appendix B**

**OIG Contact and Staff Acknowledgements**

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Contact	For more information about this report, please contact the OIG at (202) 461-4720
Acknowledgments	Myong Brown Joseph Houston Victor Rhee Murray Leigh Thomas Seluzicki

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