

Date: September 12, 2017

From: Inspector General

Subj: Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act

To: Secretary of Veterans Affairs

I am submitting this letter pursuant to the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), which requires the Inspector General of the Department of Veterans Affairs (VA) 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 (Choice Fund) have been exhausted.<sup>1</sup> The report is 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."

Although my office has received no formal notice that you have made this determination, we had already begun two audits regarding Choice claims payment processes in anticipation of receiving that notice. We understand as a result of conversations with your staff in the Office of Community Care (OCC) that 75 percent of the amounts deposited in the Choice Fund have now been exhausted.

This letter describes the status of the two audits, as well as an additional audit we anticipate beginning before the calendar year end.<sup>2</sup> Of the two ongoing audits, the first, which began in January 2016, covers the claims payment process that used the Fee Basis Claims System (FBCS) managed via VA's Financial Services Center (FSC). The second, which began in March 2017, encompasses what we refer to as the "bulk payment" process first implemented in March 2016 to enable the payment of claims in the aggregate without pre-payment adjudication by VA staff. The third audit, now being planned, will review the current, more-automated payment process put in place earlier this year, which again uses the FSC.

The effort to complete an audit of the Choice payment processes within 30 days of reaching the 75 percent threshold was frustrated by two unforeseen factors: First, the significant changes made by VA in late 2016 to its claims processing methodologies, as described in this letter, necessitated that we start a second audit into that very different process in March 2017. Second, the rapid increase in Choice spending reported by VA in the spring of 2017 resulted in an unanticipated acceleration of the time frame in which 75 percent of the allocated funds were exhausted. Nevertheless, we have made significant progress and will publish the results of both audits by the end of calendar year 2017.

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<sup>1</sup> Pub. L. No. 113-146, § 101(o), 128 Stat. 1754, 1763.

<sup>2</sup> This letter references and relies upon information and data we have been provided by OCC as of September 8, 2017.

## **Brief Background of the Choice Program**

As you know, in August 2014, Congress enacted VACAA to enable eligible veterans to obtain medical care outside of the VA medical system from providers in their communities.<sup>3</sup> (This will be referred to as the “Choice Program.”) The legislation appropriated \$10 billion to the Choice Fund, which is segregated from other monies allocated to VA for health care. The Choice Fund was to be spent on care specifically authorized under by VACAA, as well as the administrative expenses associated with establishing and maintaining the Choice Program. The following year, Congress authorized VA to use Choice Funds for additional categories of care, such as treatment for Hepatitis C, and expanded eligibility for the Choice Program.<sup>4</sup> Congress also required VA to develop a plan to consolidate all non-VA community care programs<sup>5</sup> and to address a number of elements, including “the structuring of the billing and reimbursement process, including the use of third-party medical claims adjudicators or technology that supports automatic adjudication.”<sup>6</sup> Invoices for medical care provided under Choice are processed on behalf of VA by two third-party administrators (TPAs): Health Net Federal Services LLC (Health Net) and TriWest Healthcare Alliance (TriWest). The services provided by the TPAs are governed by contracts between each TPA and the VA (TPA contracts) and include building provider networks, scheduling appointments, collecting medical documentation, and making payments for medical care.

The TPA contracts require the providers of medical treatment to send their invoices to the TPAs, which pay the providers for these medical services and then bill VA for reimbursement. VA initially processed all invoices received from and payments to the TPAs for medical claims through FBCS, which had been the claims processing system used for processing and payment of non-VA medical care claims by VHA. FBCS was manual and cumbersome and significant delays in payments to the TPAs were common. VA subsequently modified its process to enable it to pay large numbers of outstanding claims at one time outside the FBCS process. More recently, VA has implemented its automated claims adjudication and payment system via FSC which is intended to improve efficiency. VA’s experience with each of these claims processing systems is the subject of our ongoing or future audit work.

## **Audits of Choice Payment Processes**

As discussed, OIG has three audits underway or anticipated regarding the timeliness and accuracy of Choice payment processes. We anticipate two of these audits being completed during 2017, and the results will be reported to VHA and published consistent with our standard practice. These audits are discussed below.

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<sup>3</sup> Eligibility for Choice is based on specific criteria relating to wait times for appointments and distance from the nearest VA medical facility.

<sup>4</sup> See VA Budget and Choice Improvement Act, Pub. L. No. 114-41, 129 Stat. 443 (July 31, 2015).

<sup>5</sup> VA has for a number of years had programs in place to enable veterans who could not be served at their local VA Medical Center to receive medical care and services from providers in their communities. These programs have included Project Access Received Closer to Home, the Non-VA Care Program, and Patient-Centered Community Care. Generally, these medical services were paid for out of the budgets of the medical center to which the veteran was assigned and claims for these services were not processed centrally.

<sup>6</sup> Pub. L. No. 114-41, § 4002(b)(4), 129 Stat. 443, 461.

## *Audit of the Timeliness and Accuracy of Choice Payments Processed Through FBCS*

Following the implementation of the Choice Program, OIG's Audit staff began monitoring Choice obligations and expenditures using general ledger reports from VA's Financial Management System. Our staff obtained a sample of claims processed for payment through FBCS from November 1, 2014 through September 30, 2016, which were tested to determine the timeliness and accuracy of those payments. In the aggregate, OIG's Audit staff reviewed quarterly samples of payment transactions from the combined total of \$649 million in claims paid to the two TPAs—\$580 million to TriWest and \$69 million to Health Net<sup>7</sup>—all of which were processed through FBCS.

Based on an analysis of sample data, we identified the following errors:

- Duplicate Errors—Payments for medical claims that have been paid more than once
- Other Health Insurance<sup>8</sup> (OHI) Errors—Payments that were not adjusted for the amount OHI was responsible to pay the provider
- Pass-Through Errors—Payments to reimburse the TPA that were more than the TPA paid the provider
- Rate Errors—Payments that did not use the appropriate Medicare or contract adjusted rate

Our Audit staff has attributed these errors to the lack of an appropriate payment process for Choice claims and an ineffective internal control system for that payment process. As a result, we estimate that OCC overpaid the TPAs tens of millions of dollars from November 1, 2014 through September 30, 2016 for claims processed through FBCS.<sup>9</sup> More specific information about these estimates and our sampling methodology will be provided in the report of this audit.

The error category known as Pass-Through requires explanation. VA had previously awarded the two TPAs contracts to administer the similar Patient-Centered Community Care Program (PC3). The PC3 contracts (which were amended to add provisions governing the administration

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<sup>7</sup> This review covered \$649 million in paid claims data for Choice medical care from FYs 2015 and FY 2016 that was obtained from the VA Central Fee Inpatient and Outpatient Fee tables. It did not include any payments for: (i) Choice administrative payments; (ii) Choice medical care under either of the two bulk payment programs, VCPBYPASS or Expedited Payments, introduced under contract modifications in FY 2016 and described more fully below; or (iii) payments for Hepatitis C and emergency care using Choice Program funding as authorized by the Surface Transportation and Veterans Health Care Choice Improvement Act passed in July 2015.

<sup>8</sup> Veterans who are eligible for VA-provided health benefits are frequently eligible for and covered by other health insurance as well, such as employer-sponsored plans; this additional available coverage is referred to in this letter as OHI. Until VACAA was amended in April, OHI was the primary payer for nonservice-connected care for veterans, and the providers were required to bill the OHI carrier first, with the TPAs to then seek reimbursement from the VA for the remaining amount.

<sup>9</sup> OCC does not have a policy and procedure manual to guide the TPAs in processing claims; in our audit work, 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.

of the Choice Program) did not prevent the TPAs from negotiating rates with providers that were lower than the Medicare rates VA would pay for services and specifically allowed the TPAs to retain the benefit of these negotiated discounts. Thus, the TPAs were allowed to retain the difference between the negotiated amount and the amount VA would pay for a particular service and to not “pass through” the negotiated savings. The modifications to those contracts for the Choice Program, however, provided that: “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...” Many of the health care providers who were in the PC3 network were also in the Choice network; TPAs were allowed to refer patients authorized under Choice to providers who were in the PC3 network with whom they had negotiated discounted rates, and some of these providers billed at their PC3 rates for Choice authorizations as well. The TPAs asserted that the contracts were not clear about their responsibility to pass through discounted PC3 rates for services provided under Choice but billed by the provider with the PC3 discount applied, and the TPAs were not passing through the discounted rates when they were applied to Choice services (*i.e.*, they were billing VA at the approved Medicare rate for Choice services and keeping the difference between that rate and the lower PC3 discounted rate billed by the provider). When it discovered this issue, VA determined the contracts should be modified to more explicitly state that a pass-through of negotiated discounts was required for Choice referrals.<sup>10</sup>

#### *Audit of Bulk Payments Made Outside the FBCS Process via Contract Modifications*

In addition to the payment errors discussed above, by March 2016, other payment-related issues were affecting the Choice Program. VA leadership has reported that demand for Choice and the corresponding volume of claims began increasing significantly in 2016, and the submission of hundreds of thousands of claims was being held up because of missing medical documentation.<sup>11</sup> As a result, OCC was significantly behind in reimbursing the TPAs for payments made to the network providers for care provided to veterans. Backlogs of this magnitude presented significant difficulty for the TPAs, which began pushing for a solution. Ultimately, VA and the TPAs entered into modifications to the TPA contracts that allowed payments on Choice claims to occur without undergoing the adjudication and payment process through FBCS; instead, the claims were paid with minimal review and on an aggregated basis. Two TPA contract modifications were executed. First, in March 2016, a modification referred to as VCPBYPASS was made to address claims and payments delayed because of medical documentation issues. Second, in October and November 2016, modifications were made to address processing delays in the context of high claim volumes, which we refer to as Expedited Payments.<sup>12</sup> We refer to these payment types collectively as “Bulk Payments.” VCPBYPASS payments were made on

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<sup>10</sup> This is known as the “pass-through modification”: Modification 9 for Health Net and Modification 10 for TriWest.

<sup>11</sup> The TPA contracts initially required that providers submit medical documentation before they could be paid, but many providers failed to comply with this requirement. Because of a concern that providers would drop out of the networks if they were not paid, the contracts were modified to enable the TPAs to pay providers without regard to whether required medical documentation had been received. See Modification 17 for both Health Net and TriWest (colloquially known as the “decoupling mod.”)

<sup>12</sup> VCPBYPASS is authorized by Modification 21 for TriWest and Modification 20 for Health Net. Expedited Payments are authorized by Modification 33 for TriWest and Modifications 30 and 33 for Health Net.

several different dates in 2016 as the TPAs provided the batched claims via Excel file; Expedited Payments began in October 2016 and continue to be made on a weekly basis, based on an aggregation of individual claims submitted by the TPAs. We understand that Expedited Payments will continue to be made until all claims for services during the relevant time frame have been paid.<sup>13</sup>

As set forth in the following table, total claims and payments made under the Bulk Payment processes as of August 1, 2017 are sizable:

	<b>Claim Count</b>	<b>Billed Amount</b>
<b>Expedited Payment</b>	<b>5,064,883</b>	<b>\$1,811,736,242</b>
<b>VCPBYPASS</b>	<b>522,902</b>	<b>\$175,706,446</b>
<b>Totals</b>	<b>5,587,785</b>	<b>\$1,987,442,688</b>

OIG Audit staff, recognizing that the Bulk Payment process significantly increased the opportunity for payment errors—since the claims would now be paid on an aggregated basis without any pre-payment adjudication by OCC—began an audit of these bulk payments in March 2017. Audit work performed to date indicates that while OCC staff undertook some prepayment review in an effort to identify potential duplicate claims, the review was ineffective. VA undertook no other review or adjudication of hundreds of thousands of medical claims prior to payment to the TPAs.<sup>14</sup> Our audit work to date demonstrates the existence of tens of thousands of duplicate payments. As with our audit of Choice claims paid through the FBCS process, Audit staff are also performing a review of a statistically valid sample of claims for other categories of payment errors, including payment errors using pricing outside of contract terms, pass-through errors where invoices billed at negotiated rates were not properly billed to VA by the TPAs, and insurance offset errors where VA payments were not properly offset by collections from veterans’ OHI.

Although it was contemplated by the modifications to the TPA contracts that procedures would be implemented to ensure that duplicate and other improper claims were not paid in the Bulk Payment environment, our audit work to date indicates that these efforts were ineffective at best. VA and the TPAs recognized the likelihood of increased payment errors in this environment, and the Expedited Payment modifications contain provisions imposing responsibility on VA to both take steps to ensure that duplicate payments do not occur and to “complete a post-payment audit of all expedited payments to determine if claims were invoiced and paid correctly and no

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<sup>13</sup> For claims processed through TriWest, this constitutes all claims for services provided before February 13, 2017, and for Health Net, all claims for services provided before April 1, 2017.

<sup>14</sup> Procedures developed to attempt to identify duplicates prior to being processed for bulk payment were rudimentary at best, relying on only the claim identification number. We understand that this process is now being automated in the new FSC process and at least a sizable percentage of duplicate claims are being identified pre-payment.

duplicate payments occurred.”<sup>15</sup> If, as anticipated, errors occurred, “steps will be taken to recover those overpayments/duplicate payments by offsetting future payments.” However, as of August 18, 2017, no formal post-payment audit of paid claims has been undertaken as required by the Expedited Payment contract modifications. We have been informed that OCC is in the process of soliciting vendors to perform the requisite post-payment audit services, and that this contract is expected to be awarded within nine months. Information obtained from the TPAs during our audits indicates that neither has effective processes for preventing duplicate payments; identifying them and providing reimbursement to VA when they occur; or properly reconciling their accounts receivable against payments received to identify large volumes of overpayments. These deficiencies must be addressed in the process of awarding additional contracts to any TPAs that may be selected for the future iteration of the Choice Program currently under consideration by Congress.

In fact, one of the TPAs recently acknowledged receiving significant overpayments from VA. By letter dated July 6, 2017, TriWest notified VA through its Contracting Officer that it had engaged the services of a consultant to determine whether TriWest had received overpayments from VA, and, if so, the conditions that led to those overpayments. TriWest advised VA that, based on its preliminary work, the consultant had identified approximately 58,000 claims that had been improperly paid, representing a total of approximately \$35 million in overpayments by VA to TriWest (\$28 million of which was attributed to Choice payments).

Since receipt of that letter, VA staff has also addressed with the TPAs its internal data reflecting the existence of significant overpayments. Although not a post-payment audit, OCC has developed a database comprising all paid Choice claims (internally referred to as the “PIT Tool”). Applying certain business rules and data analytics tools to that data, OCC’s Department of Program Integrity (DPI) has undertaken a process to identify duplicate payments.<sup>16</sup> As a result of this work, on July 18, 2017, VA’s Contracting Officer sent a letter to both Health Net and TriWest informing each of the identification of overpayments by VA and providing a spreadsheet of data on a claim-level basis showing duplicate payments to the TPAs, which DPI found totals approximately \$89.7 million (\$38,872,275.12 for TriWest and \$50,798,948.55 for Health Net). The letters instructed the TPAs to review the claims data and provide any rebuttal on a per-claim basis, which was to be followed by a Bill of Collection to be issued by VA and paid by each TPA.<sup>17</sup>

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<sup>15</sup> TriWest Modification 33; Health Net Modification 30. It is unclear why VA would agree to contract terms that impose such a heavy and unequal burden upon it, rather than on the TPAs, to protect against duplicate payments. It must also be noted that the contracts, in compliance with Federal Acquisition Regulations, require that if a TPA becomes aware of duplicate or other overpayment, it must remit the overpayment to VA and describe the circumstances of the overpayment. FAR 52.232-25(d) (2017).

<sup>16</sup> We have also recently been informed that OCC is attempting to perform an automated review of paid claims in an effort to identify pricing errors that occurred in the Bulk Payment environment, but we have not been provided any reports or data reflecting the outcome of those efforts.

<sup>17</sup> As indicated, OIG’s Audit staff are in the process of performing similar duplicate payment analytics on all Choice claims paid via the Bulk Payment process, and preliminary results with regard to duplicate payments are reasonably consistent with those recently identified and verified by DPI using the PIT Tool. OIG Audit staff are continuing discussions with DPI staff regarding their methodology, including

In recent interviews with our Audit staff, both TPAs acknowledged errors in processing Choice payments that have resulted in overpayments by VA. The reasons expressed by each TPA for these errors are varied and complex, and will be addressed in our pending reports.

The TPAs are obligated by contract and law to return all overpayments to VA. OIG staff, in collaboration with OCC staff and members of VA's Office of General Counsel, are working with relevant Government authorities to review and determine an appropriate process for reimbursement and otherwise resolve any potential claims for damages against the TPAs arising from all overpayments identified during the course of our audits. We anticipate that additional information about these recovery efforts will be made available in the coming months.

#### *Anticipated Audit of OCC's Current Payment Processing System*

While we believe VA has made some progress in its efforts to improve its payment processing systems for claims received for medical services provided after the period covered by the Expedited Payment modifications, we are concerned that significant issues with the timeliness and accuracy of payments under the Choice Program identified through our pending audits may not have been adequately addressed in OCC's new payment processing environment. The current processes, more fully described below, will be the subject of future work by our Audit staff.

VACAA required that VA retain a third-party to assess VA's health care delivery systems and processes (Independent Assessment).<sup>18</sup> The Independent Assessment, submitted to Congress in September 2015, included a discussion of VA's systems for making payments to outside providers:

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 payments 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>19</sup>

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assessing the business rules and duplicate logic used by DPI, in an effort to understand and reconcile any differences in methodology and outcomes.

<sup>18</sup> Pub. L. No. 113-146, § 201(a), 128 Stat. 1754, 1769.

<sup>19</sup> CMS Alliance to Modernize Healthcare, *Independent Assessment Of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* 45 (2015), [https://www.va.gov/opa/choiceact/documents/assessments/Integrated\\_Report.pdf](https://www.va.gov/opa/choiceact/documents/assessments/Integrated_Report.pdf).

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>20</sup> Furthermore, a Government Accountability Office report mandated by VACAA and published in May 2016 (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.<sup>21</sup>

Consistent with the recommendations in the Independent Assessment and the GAO Report, we understand that VA looked for an automated alternative to its manual claims adjudication process and engaged in efforts to improve its payment processes. In February 2017, VA’s FSC began using new medical claims adjudication software, Plexis Claims Manager, to process Choice claims with treatment dates after February 13, 2017 for claims processed through TriWest and April 1, 2017 for claims processed through Health Net.<sup>22</sup> This new process was implemented to replace the FBCS process and is the subject of a Service Level Agreement between FSC and OCC documenting the services to be provided by FSC. The Plexis software features the ability to automate the eligibility verification process and the identification of duplicate claims, allows for the importing of authorization/claim data, and automates the comparison of rates charged for medical services in a claim against contracted rates. It was expected that this more automated process would allow higher claim volumes to be managed with existing FSC resources and increase accuracy. We will review this payment processing system in a future audit and make further findings and recommendations as appropriate.

In conclusion, making accurate and timely payments in the Choice Program has proven to be a significant challenge for VA, and, based on our pending audit work, identified payment errors total in the tens of millions of dollars. VA has taken steps recently to address issues that resulted in the overpayments to date, including automating more of its payment processing system going forward, but it appears likely that this process will continue to be a challenge. VA needs to carefully identify the causes of all past payment errors, identify and validate all payment errors of any type in both the FBCS and Bulk Payment environments, and continue to cooperate in efforts to obtain reimbursement for overpayments. It also must ensure that similar (or different) issues and problems do not plague its new, more-automated FSC claims payment process. Finally, it must prepare and release a robust and detailed written plan to address claims and payment processing for the new iteration of its community care program, to include a written

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<sup>20</sup> *Id.* at I-3.

<sup>21</sup> U.S. Government Accountability Office, GAO-16-353, *Veterans’ Health Care: Proper Plan Needed to Modernize System for Paying Community Providers* (2016), <http://www.gao.gov/assets/680/677051.pdf>. Although recommended, to our knowledge, no written plan has been prepared, and we understand that OCC has informed GAO that it intends to do so only once Congress has enacted legislation creating the next iteration of VA’s community care program. See U.S. Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care* ((2015), [https://www.va.gov/opa/publications/VA\\_Community\\_Care\\_Report\\_11\\_03\\_2015.pdf](https://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf)).

<sup>22</sup> Claims relating to services prior to these dates continue to be processed through the Expedited Payments process described above, and this process will continue until all such claims have been processed. VA has refined its processes for identifying duplicate claims in this bulk payment environment before they are paid; staff are also working to enhance VA’s ability to identify other improper payments both before and after they are made. These remain areas of concern.



policy and procedures manual. Our audit work on the various iterations of the claims payment processes continues, and as discussed, we will publish reports setting forth our findings and recommendations arising from these audits in the coming months.

I am happy to address any comments or questions you have.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael J. Missal". The signature is fluid and cursive, with a large loop at the end.

Michael J. Missal

cc: Chairman and Ranking Member, Committee on Veterans' Affairs, U.S. House of Representatives  
Chairman and Ranking Member, Committee on Veterans' Affairs, U.S. Senate  
Chairman and Ranking Member, Committee on Appropriations, U.S. House of Representatives  
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Chairman and Ranking Member, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, U.S. House of Representatives  
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