DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts

AUDIT | REPORT #17-02713-231 | SEPTEMBER 6, 2018

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Executive Summary

Why the OIG Did This Audit

The Department of Veterans Affairs, Office of Inspector General, conducted this audit to determine the accuracy of aggregated payments made to third-party administrators (TPAs) under the Patient-Centered Community Care (PC3) Program contracts, which include care provided under the Veterans Choice Program (Choice). Both programs enable veterans to obtain care from providers in their community and are administered under contracts entered into in 2013 with two TPAs, Health Net Federal Services and TriWest Healthcare Alliance Corporation, for PC3 (the TPA contracts). The TPA contracts were modified to incorporate Choice after the enactment of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) in 2014. Under these contracts, TPAs perform a variety of administrative services for these two programs, including processing and payment of claims from community providers who provide care to veterans. These contracts were amended in 2016 to enable the Veterans Health Administration's (VHA) Office of Community Care (OCC) to process payments on an aggregated basis (referred to as "bulk payments"). This is the second of two reports on OCC's process for paying claims under Choice. This report addresses "bulk payments" made from March 4, 2016, through March 31, 2017, under the 2016 modifications to the TPA contracts. A prior audit report released by the OIG last year addressed claims processed through the Fee Basis Claims System (FBCS).[1]

What the OIG Found

The OIG determined that TPAs submitted, and OCC made, 253,641 duplicate payments on 4,758,759 claims (5.3 percent) through the bulk payment process from March 4, 2016, through March 31, 2017. For purposes of analyzing the existence of duplicate payments, the OIG segregated duplicate claims that caused overpayments into two categories. The first category, *Adjusted Claims*, comprises duplicate claims resulting when TPAs resubmitted a claim with a different adjusted amount. The second category, *Unadjusted Claims*, comprises duplicate claims resulting when TPAs resubmitted claims without an adjusted amount (that is, the same-billed amount).

[1] *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (Report No. 15-03036-47, December 21, 2017)

Table 1 summarizes duplicate claims by type for Health Net and TriWest.

Table 1. Summary of Duplicate Claims by Type

TPA	Adjusted Claims	Unadjusted Claims	Total Duplicate Payments
Health Net	54,885	87,608	142,493
TriWest	49,532	61,616	111,148
Total Duplicates	**104,417**	**149,224**	**253,641**

Source: VA OIG duplicate analysis of bulk payments made to Health Net and TriWest from March 4, 2016, through March 31, 2017, and analysis of FBCS payments made to Health Net and TriWest from November 1, 2014, through March 31, 2017. Duplicates were identified by matching claims paid in the bulk payment environment against each other in addition to claims paid in the FBCS environment for the identified periods.

In addition, the OIG estimated OCC made other payment errors on 10 percent of payments submitted by TPAs in the context of bulk payments. These errors fell into three categories:

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

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

Pass-through: Payments made on Choice claims where OCC reimbursed the TPA more than the TPA paid the provider

Table 2 shows the number of other payment errors made by each TPA for the period from March 4, 2016, through March 31, 2017.

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

TPA	Payment Rate	OHI	Pass-through	Total Errors
Health Net	36,800	147,000	-	183,800
TriWest	273,000	-	22,700	295,700
Total Errors	**309,800**	**147,000**	**22,700**	**479,500**
Percentage of Error	6.5%	3.1%	0.5%	10%

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017.

**Table contains rounded projected estimates. The total percentage of error is rounded to the nearest whole percentage.*

Because of ineffective internal controls, OCC failed to identify improper claims being submitted by TPAs. This resulted in estimated overpayments of about $66.1 million in duplicate payments

and $35.3 million in three other payment error types, for a total of $101.4 million in estimated overpayments to TPAs, as referenced in Table 3.

Table 3. Total Estimated Overpayment Dollars by Error Type

TPA	Duplicate Payment	Payment Rate	OHI	Pass-through	Total
Health Net	$32.1 million	$7.1 million	$16.8 million	N/A	$56.0 million
TriWest	$34.0 million	$11.2 million	N/A	$0.2 million	$45.4 million
Total	**$66.1 million**	**$18.3 million**	**$16.8 million**	**$0.2 million**	**$101.4 million**

Source: VA OIG duplicate analysis of bulk payments made to Health Net and TriWest from March 4, 2016, through March 31, 2017, and analysis of FBCS payments made to Health Net and TriWest from November 1, 2014, through March 31, 2017. VA OIG payment error projections (Payment Rate, OHI, Pass-through) based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017.

Why This Occurred

OCC paid duplicate claims that had been improperly submitted by TPAs because of a lack of proper internal controls in the bulk payment process. Prior to the initiation of the bulk payment process, FBCS and Financial Services Center (FSC) claim reviewers reviewed each claim processed through FBCS individually; this process involved a review intended to prevent duplicate payment errors. In addition, claims processed in FBCS were routed through a tool used by OCC's Department of Program Integrity, referred to as the Program Integrity Tool (PIT), which reviewed the claims for potential duplicates prior to payment. However, processing claims individually through FBCS was time-consuming and resulted in a backlog of unpaid claims to TPAs. To make payments to TPAs faster and reduce this backlog, OCC implemented the bulk payment process, which removed the review of each individual claim when processed in FBCS with the intent of improving payment timeliness; however, OCC did not implement effective internal controls to detect the submission of duplicate claims by TPAs and to prevent payment errors.

Other payment errors occurred because OCC did not effectively follow internal control principles identified in the Government Accountability Office's *Standards for Internal Control in the Federal Government*, including:

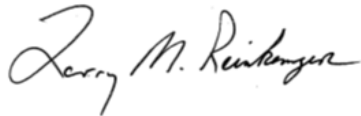
- Create clear written policy to establish and enforce internal controls over the payment process
- Ensure access to quality information is available for payment processing staff
- Use a well-designed information system to address the risk of overpaying medical claims
- Establish monitoring activities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

What the OIG Recommended

The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, ensure proper processes are in place to prevent payment of duplicate claims submitted by TPAs. The OIG also recommended the Office of the Under Secretary for Health ensure that 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 to obtain reimbursement of the identified overpayments.

Management Comments

The Executive in Charge, Office of the Under Secretary for Health, concurred with the OIG findings and recommendations. The Executive in Charge provided acceptable action plans for both recommendations. The OIG will monitor VHA's progress and follow up on the implementation of the recommendations until all proposed actions are completed.



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Abbreviations

FBCS	Fee Basis Claims System
FSC	Financial Services Center
FY	Fiscal Year
IT	Information Technology
MCCF	Medical Care Collection Fund
OCC	Office of Community Care
OHI	Other Health Insurance
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
PCM	Plexis Claims Manager
PCN	Patient Control Number
PIT	Program Integrity Tool
TPA	Third-Party administrator
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VistA	Veterans Information Systems and Technology Architecture
VHA	Veterans Health Administration
WPS	Wisconsin Physicians Service

Introduction

Objective

The Department of Veterans Affairs, Office of Inspector General, conducted this audit to determine the accuracy of aggregated payments made to TPAs under the PC3 contracts, which include care provided under the Veterans Choice Program (Choice). Both the PC3 and Veterans Choice Programs enable veterans to obtain care from providers in their community. They are administered under contracts entered into with two TPAs, Health Net Federal Services (Health Net) and TriWest Healthcare Alliance Corporation (TriWest), in 2013 for PC3 (the TPA contracts). These contracts were modified to incorporate Choice after the enactment of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) in 2014.[2] Under these contracts, TPAs perform a variety of administrative services for these two programs, including processing and payment of claims from community providers who provide care to veterans. In 2016, these contracts were amended to enable VA to process payments to TPAs on an aggregated basis (referred to as "bulk payments"). This is the second of two reports on the Veterans Health Administration (VHA) Office of Community Care's (OCC) process for paying claims under Choice; this report addresses bulk payments made from March 4, 2016, through March 31, 2017, under the 2016 modifications to the TPA contracts.[3]

Program History

OCC, under the leadership of the Deputy Under Secretary for Health for Community Care, is responsible for the administration of PC3 and Choice. PC3 is a VHA nationwide program to offer non-VA health care to eligible veterans when VHA facilities cannot readily provide care to veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. In September 2013, VA awarded Health Net and TriWest contracts to perform administrative duties and to facilitate the provision of healthcare services to veterans by a network of community providers.[4]

On August 7, 2014, VACAA was enacted to improve veterans' access to medical services by appropriating $10 billion for veterans to receive care from non-VA providers. Eligibility for

[2] Public Law 113-146, 128 Stat. 1754 (August 7, 2014).

[3] Report No. 15-03036-47, dated December 21, 2017, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, addressed claims processed through the Fee Basis Claims System (hereinafter referred to as the "FBCS Payment report"). These two reports follow a memo from the Inspector General on these topics, "Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act," published on September 12, 2017.

[4] TriWest entered into a sub-contracting arrangement for claims processing services with Wisconsin Physicians Service. Because TriWest is responsible for its subcontractors, the OIG will not differentiate between activities performed by the two entities and will refer solely to TriWest for the purposes of this report.

Choice is based on specific criteria relating to wait times for appointments and distance from the nearest medical facility.

To implement the requirements of VACAA, in October 2014, VHA amended the PC3 contracts to include the administration of Choice. VACAA required VA to implement key portions of Choice within 90 days, and veterans began using Choice by November 2014. Table 4 summarizes Choice medical care expenditures beginning October 1, 2014, through March 31, 2018.

Table 4. Total Choice Medical Care Expenditures*

Fiscal Year	Medical Expenditures
Choice Medical Care – FY 2015	$27 million
Choice Medical Care – FY 2016	$1.23 billion
Choice Medical Care – FY 2017	$4.69 billion
Choice Medical Care – FY 2018; Quarters 1 & 2	$1.90 billion
Total	**$7.84 billion***

Source: Financial Management System 827 General Ledger report disbursement totals as reported for Veterans Choice Fund - 0172XB Medical Care as of March 31, 2018
**Table results are rounded numbers. As a result, column does not sum exactly to the total.*

Under an agreement with the VA Financial Services Center (FSC), Choice claims for medical services were initially processed individually via the Fee Basis Claims System (FBCS).[5] According to the FSC, they began receiving large volumes of Choice claims transmissions starting in FY 2016 quarter 1 from TPAs. This increase in claims volumes led to an increased backlog of unpaid claims as the FSC struggled to process claims within 30 days in accordance with the Prompt Payment Act standards.[6]

Figure 1 illustrates FSC's quarter-over-quarter increase of unpaid claims aged over 30 days as Choice claims volume increased then decreased after the bulk payment process was fully implemented.

[5]The FSC is a VA Franchise Fund that provides administrative support services on a fee-for-service basis.

[6] Public Law 113-146 (August 7, 2014), Veterans Access, Choice, and Accountability Act of 2014, 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 Code of Federal Regulations part 1315 – *Prompt Payment*.

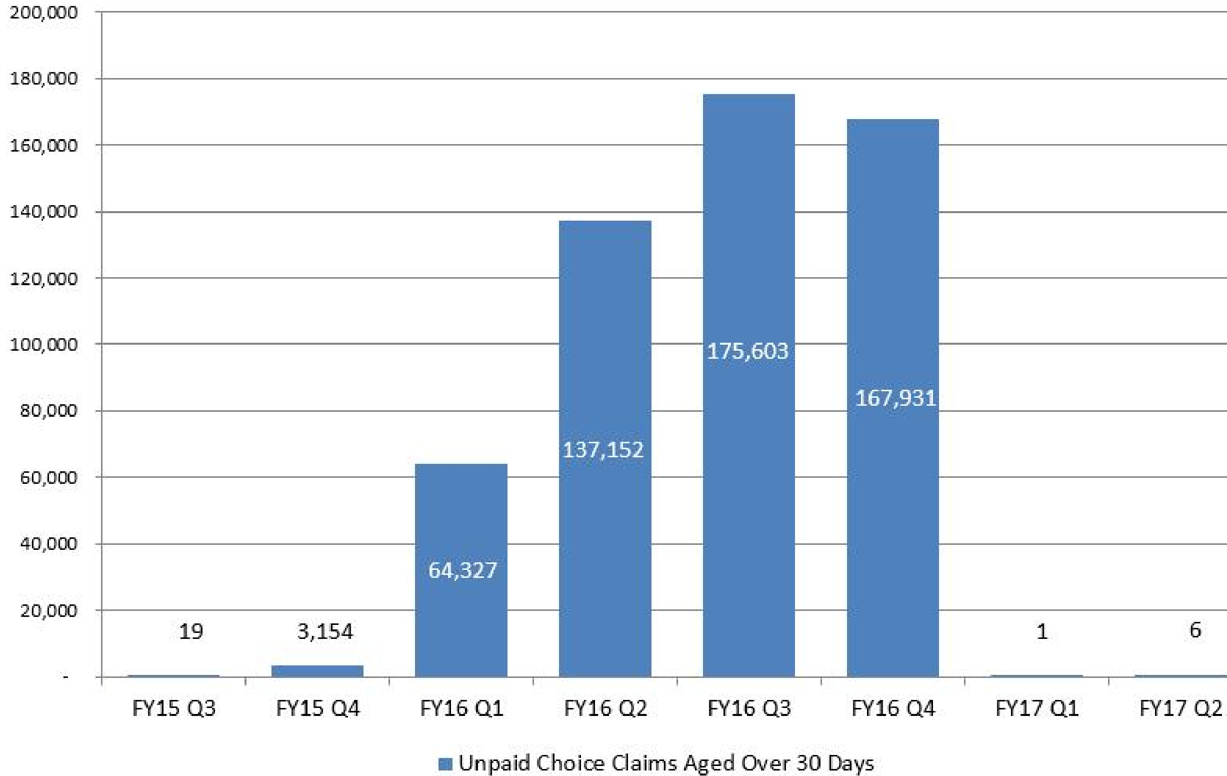

Figure 1. *Ending inventory of unpaid Choice claims aged over 30 days in FBCS by quarter (Source: Financial Services Center Supervisor, VHA purchased care claims)*

Claims Payment Processes

OCC does not have a policy and procedure manual to guide TPAs in processing PC3 and Choice medical claims. Both TPAs reported 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 healthcare program. However, TPAs are obligated by contract to submit claims at the appropriate contract rates, and the contract further states, "The contractor shall employ industry best practices that monitor compliance and support internal controls to prevent fraud, waste, abuse, and improper payments."

VA initially processed all claims received from TPAs via FBCS, which had been the claims processing system used by VHA for processing and payment of most non-VA medical care claims. PC3 claims were processed at the authorizing VA medical facility; however, Choice claims are routed centrally to the St. Louis VA Medical Center FBCS system and then processed remotely in FBCS by the FSC in Austin, Texas. For a veteran's claim to be processed in the St. Louis FBCS for payment, a profile for that veteran must be first created in a separate system

called Veterans Information Systems and Technology Architecture (VistA). As a result, if a veteran was not registered in the St. Louis VistA system, the FSC was required to manually create a veteran profile before a Choice claim could be processed for payment in FBCS. FSC then verified or created a Choice authorization and reviewed each claim to determine if the claim was a potential duplicate prior to approving payment. The result was that use of FBCS as a means to centrally process Choice claims required significant staffing. By October 2015, when VA submitted its report to Congress on consolidating community care programs as required by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, OCC conceded that it was not able to process claims in a timely fashion or meet applicable legal requirements for the timeliness of payments.[7]

Medical documentation requirements created an additional challenge in the process of getting medical claims paid. The TPA contracts initially required that VA receive medical documentation related to the services provided before claims could be processed for payment. Providers were required to submit medical documentation to TPAs, which were then required to submit the documentation to VA before billing VA for medical services.[8] The medical documentation requirement resulted in significant delays in payments to providers because TPAs were denying providers' Choice claims when documentation had also not been received. Payment delays caused concern about providers dropping out of networks, thus negatively affecting veterans' access to care. This led to a modification of the TPA contracts in March 2016, colloquially known as the "decoupling mod," which removed the requirement that medical documents must be received by VA before it could pay TPAs.[9] The decoupling modification required VA to address hundreds of thousands of claims that had been withheld by TPAs pending receipt of medical documentation, which, if submitted to VA at one time, would have resulted in a significant backlog.

The payment process for Choice claims was further complicated by VACAA requirements that nonservice-connected care first be billed to a veteran's other health insurance (OHI) by the provider. Unlike PC3, where VA is the primary payer on all claims, the Choice contract provisions require TPAs to ensure that the provider bills a veteran's OHI prior to the TPA invoicing VA for nonservice-connected care. Once OHI has paid its portion of the care, TPAs send a claim to VA for remaining costs, up to the allowable Medicare rate, that were not covered

[7] VA acknowledged the inefficiency of its manual processes but stated it lacked a centralized data repository that would allow it to more readily auto-adjudicate claims. *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, submitted to Congress by VA on October 30, 2015, Section 4.4, pp. 48–50.

[8] According to VA, this requirement was not industry standard, and it often resulted in delays in payment. *Plan to Consolidate*, §4.4, pp. 48–50.

[9] Modification 17 for both Health Net and TriWest.

by OHI. If the care was service-connected, or the veteran was nonservice-connected and did not have OHI coverage, the TPA is to bill VA at the appropriate rate for the services provided.[10]

PC3 medical claims were subject to agreements between TPAs and their providers, with whom TPAs could negotiate rates below the allowable Medicare rate.[11] Under the TPA contracts, TPAs could refer veterans to providers who are in either their PC3 or Choice networks. The PC3 contracts allow TPAs to negotiate rates with PC3 network providers who may be below Medicare rates. Under the Choice provision of the contract, Choice providers are paid up to 100 percent of the Medicare rate under the provisions of the Choice-specific modification to the TPA contract, and the TPA contracts require TPAs to bill claims for services authorized under Choice as a "pass through"—that is, to bill VA the same amount they paid their providers.[12]

Finally, the TPA contracts require TPAs to reimburse overpayments to VA—citing the Federal Acquisition Regulation, the contracts state that if the TPA becomes aware of a duplicate claim payment or other erroneous payment, it shall remit the overpayment amount to the VA payment office and provide a description and circumstance of the overpayment.[13] In addition, the contracts require that a copy of the remittance and supporting documentation for the overpayment be provided to the contracting officer.

In this audit, the OIG identified approximately $101.4 million in overpayments resulting from duplicate payments, Payment Rate errors, OHI errors, and Pass-through errors.[14]

Bulk Payment Contract Modifications

To reduce the backlog and eliminate the sizable accounts receivable owed to TPAs, beginning in March 2016, OCC entered into a series of seven contract modifications with Health Net and TriWest; they are summarized in Appendix A. These contract modifications allowed three kinds of aggregated payments to TPAs, referred to as Lump Sum, VCPBYPASS, and Expedited. The OIG referred to these three aggregated payment types collectively as bulk payments.

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[10] This requirement was eliminated by amendments to VACAA in April 2017, which made VA the primary payer for a veteran's care for all services after the date of the amendment, with the ability to seek reimbursement from OHI after payment has been made to the provider by TPAs.

[11] 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.

[12] The Choice contract provisions allow TPAs to exceed Medicare in highly rural areas.

[13] The TPA contracts cite Federal Acquisition Regulation 52.212-4, *Contract Terms and Conditions–Commercial Items*.

[14] In a prior audit, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (Report No. 15-03036-47, December 21, 2017), the OIG identified overpayments of approximately $39 million to TPAs.

According to OCC, following a year of biweekly meetings with TriWest to address aged PC3 claims, efforts to resolve all aged PC3 claims were unsuccessful. OCC cited TriWest's difficulty in reconciling accounts and receiving information in electronic format. However, OCC acknowledged that VA payment sites may have incorrectly either underpaid or improperly denied some PC3 claims. In January 2016, OCC, TriWest, and VA's contracting officer's representative met to discuss claims backlogs; because of this meeting, the concept of using a Lump Sum payment method was proposed for backlogged PC3 claims.

On March 4, 2016, to reduce this backlog of unpaid PC3 claims, OCC entered into a contract modification with TriWest, referred to as PC3 Lump Sum.[15] The TriWest contract modification allowed VA to process and pay all unpaid PC3 claims with dates of service prior to January 1, 2016, in aggregate.

Later, on March 22, 2016, each TPA contract was modified, as the result of the decoupling modification referenced above, to enable a bulk payment referred to as VCPBYPASS. This bulk payment method encompassed a series of payments undertaken to address a backlog of Choice claims that had accumulated with each TPA because of previous contract requirements to submit medical documentation before billing for medical services. In October and November 2016, additional modifications were made to address Choice processing inefficiencies in the context of ongoing high claim volumes. These payments are referred to as Bulk Payments. Payments under these modifications totaled $1.65 billion through March 31, 2017, as summarized in Table 5.

The seven contract modifications allowed three types of aggregate payment methods to TPAs: The Lump Sum modification for TriWest PC3 claims, the VCPBYPASS modification for TriWest and Health Net Choice claims, and the Expedited modification for TriWest and Health Net Choice claims. Each of these modifications enabled OCC to bypass the FBCS payment process of individually reviewing and paying each claim, and instead permitted OCC to aggregate claims to be paid in bulk without an individual review of each claim.

[15] OCC was under pressure from TriWest to reduce what at the time was a sizable outstanding balance owed to the TPA.

Table 5. Dollars Paid by OCC to TPAs under the Bulk Contract Modifications through March 31, 2017

Contract Modifications[16]	Health Net	TriWest	Total
Lump Sum (PC3 Only)	N/A	$87.8 million	$87.8 million
VCPBYPASS	$133.5 million	$39.3 million	$172.8 million
Expedited	$658.5 million	$727.3 million	$1.39 billion
Total Bulk Payments	**$792.0 million**	**$854.4 million**	**$1.65 billion**

Source: VA OIG universe of PC3 and Choice claims paid via the bulk payment process for the period from March 4, 2016, through March 31, 2017

Bulk Payment Process

Under the bulk payment process, claims are submitted to OCC by TPAs using different processes.[17] Rather than processing each claim individually, OCC performs a limited review on the list of aggregated claims to confirm that veterans are eligible for PC3 or Choice, the care is authorized, and the claim has not been previously paid.[18] OCC then pays the TPA for the aggregated claims, claims continue to be processed, and payments continue to be made on a recurring basis.

[16] Two of the seven contract modifications provided only clarifying language or extensions to an existing bulk payment contract modification. TriWest Lump Sum modification 27 revised language of contract modification 20; Health Net Expedited modification 33 was executed to extend modification 30.

[17] TriWest aggregated and submitted PC3 Lump Sum claims via Microsoft Excel spreadsheets to OCC for review and payment. The claims submission process for VCPBYPASS and Expedited bulk payments differed from Lump Sum in that both TPAs submitted Choice claims consistent with the FBCS process to the VA Electronic Data Interchange, and then OCC aggregated the Choice claims for review and payment outside that process.

[18] OCC's limited prepayment review to confirm that a claim has not been previously paid was inadequate to identify duplicate claims. OCC's process to identify duplicate claims in the bulk payment environment relied solely on claims submitted with the same Patient Control Number; however, duplicate claims identified in this report were submitted primarily with different Patient Control Numbers, which would not be identified via this process. The OIG further discusses the shortfalls of this method later in this report.

Figure 2 illustrates the bulk payment process.

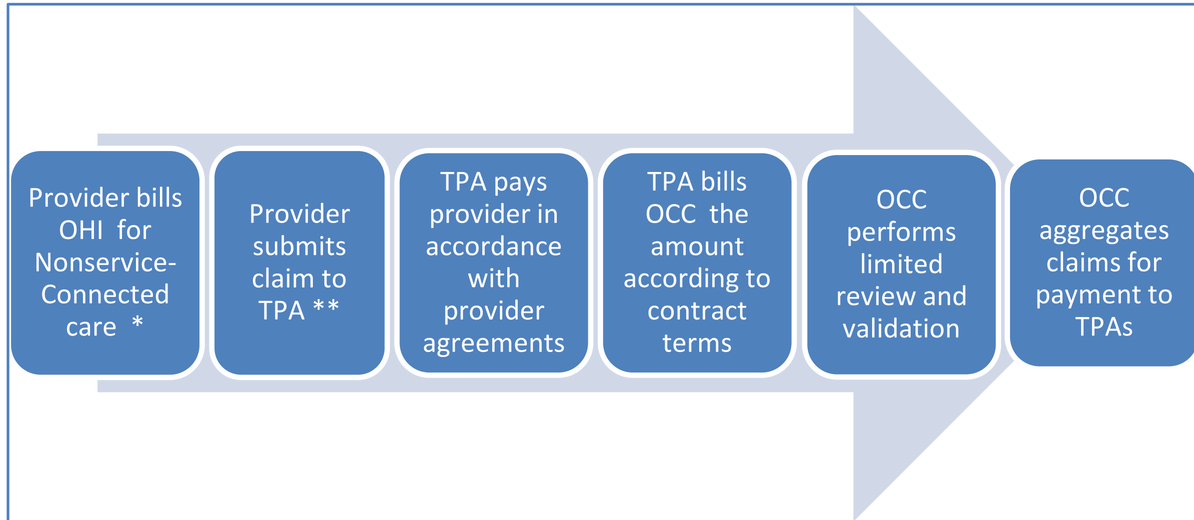

Figure 2. *Bulk Payment Process*
(Source: OIG analysis of the Choice Payment Process described in PC3/Choice Program Contracts and Modifications)
** Applies only to Choice claims. VACAA as amended provides that VA has secondary responsibility for services provided prior to April 19, 2017, if an eligible veteran is covered under a healthcare plan (that is, other health insurance) and receives care for a nonservice-connected disability.*
*** Provider may submit claims containing charges greater than the allowable contract amounts; however, TPAs are required to reimburse the provider at the rates negotiated in accordance with VACAA or PC3.*

The bulk payment process eliminated the time-consuming manual procedure required to process each individual claim for payment in FBCS. As a result, the FBCS process used to screen each individual claim for potential duplicates was not performed on claims in the bulk payment environment prior to payment. The OIG was informed that the bulk payment process was set up this way by OCC leaders because of the amount of time it takes to process claims in FBCS, which would impede the ability to process and pay the backlog of claims quickly.

An objective of the bulk payment process was to pay TPAs timely so they could pay providers timely. Both OCC and TPAs confirmed that it had been the practice of TPAs to pay providers first and then bill VA, and this process was affirmed by a contract modification effective March 1, 2016, specifically requiring TPAs to pay their network providers prior to billing VA. Thus, as of that day, the TPA contracts require Health Net and TriWest to pay the providers first and then bill VA for the medical services. This required TPAs to pay up front and then request reimbursement from VA; this was a significant impetus for the implementation of the bulk payment process. However, in the OIG sample of 145 medical claims paid from March 4, 2016, and March 31, 2017, after the bulk payment process began, 17 percent of TriWest claims and

6 percent of Health Net claims were transmitted to VA before TPAs had paid their network providers.[19]

VA recognized the likelihood that improper claims would be submitted and paid in this environment, and the Expedited contract modifications contained provisions imposing responsibility on VA to take steps both 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 duplicate payments occurred."[20] If, as anticipated, errors occurred, "steps will be taken to recover those overpayments/duplicate payments by offsetting future payments."

OCC's Department of Program Integrity initially identified the risk of duplicate payments and later performed an analysis to identify all duplicate claims paid within the bulk payment environment. According to OCC's Executive Director, Performance Improvement and Reporting, this analysis indicated a substantial number of duplicate claims that needed to be addressed and recovered, which led to letters being sent to both TPAs in July 2017; a process for obtaining reimbursement for these duplicates is underway.[21] In addition, FSC is performing a retrospective analysis limited to payment rates billed on claims. This effort is ongoing, and FSC has indicated it will report results to OCC on an iterative basis.[22]

[19] Modification 17 does not require TPAs to provide VA with documentation reflecting the date they make payment to providers on a claim, and thus VA cannot verify TPAs are complying with their contractual obligation to pay providers before billing VA.

[20] 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 itself, rather than on TPAs, to protect against duplicate payments. It must also be noted that the contracts, in compliance with the Federal Acquisition Regulation, require that if a TPA becomes aware of a duplicate or other overpayment, it must remit the overpayment to VA and describe the circumstances of the overpayment. Federal Acquisition Regulation 52.232-25(d) (2017).

[21] The amount sought from TriWest and Health Net was approximately $38,872,275 and $50,798,949, respectively.

[22] FSC has preliminary post-payment verification results that identify overbilled payment rates of Expedited bulk claims. To perform this verification, FSC is using PCM, which can verify whether appropriate rates were billed. VA OIG has not performed any review of FSC's preliminary post-payment analysis of the bulk payments and thus cannot report on the efficacy or accuracy of this process.

Results and Recommendations

Finding 1: Approximately 5.3 Percent of Bulk Payments Submitted by TPAs and Paid by OCC Were Duplicates

The OIG determined that TPAs submitted, and OCC paid, 253,641 duplicate claims on 4,758,759 medical claims (5.3 percent) to TPAs through the bulk payment process from March 4, 2016, through March 31, 2017. The OIG defines a duplicate payment error as payments for matching medical claims that were submitted and paid more than once. These errors occurred because the bulk payment process took place outside of the Choice FBCS payment process, which has steps to detect duplicate claims, and because effective internal controls were not created or implemented for the bulk payment environment to detect the improper submission of duplicate claims by TPAs.[23] This resulted in OCC overpaying TPAs about $66.1 million for duplicate claims submitted and paid from March 4, 2016, through March 31, 2017.

OCC Made Duplicate Payments

To determine whether duplicate payments occurred through the bulk payment process, the OIG developed data analytic methods to identify claims paid more than once, using key fields in each medical claim such as patient identification, date(s) of service, place of service, procedure codes, and procedure modifiers. The OIG then applied these data analytic methods to each of the approximately 4.8 million bulk payments, as well as to the approximately 3.1 million payments previously processed via the FBCS. This enabled the OIG to identify the population of duplicate payments without the need to rely on sampling.

For purposes of analyzing the existence of duplicate payments, the OIG segregated duplicate claims that caused overpayments into two categories. The first category, *Adjusted Claims*, comprises duplicate claims resulting when TPAs resubmitted an adjusted claim with a different claim amount. The second category, *Unadjusted Claims*, comprises duplicate claims resulting when TPAs resubmitted claims without an adjusted amount (that is, the same-billed amount). See Table 6 for a summary of duplicate claims by category.

[23] According to the TPA contracts, section 2(d)(ix)(d)(iii), "The contractor shall employ industry best practices that monitor compliance and support internal controls to prevent fraud, waste, abuse, and improper payments."

Deficiencies with the processes relating to identification and payment of certain types of duplicate claims in the bulk payment environment will be described in greater detail, but can be generally summarized as follows:

1. With regard to adjusted claims, TPAs had previously been instructed by OCC to submit an adjusted claim at the full amount without reducing the adjusted claim for the amount previously billed to OCC on the original claim. Under the Choice FBCS payment process, an adjusted claim was submitted by TPAs with a modification of the original claim's Patient Control Number (PCN) so that FBCS claims processors could identify an adjusted claim and pay the correct amount.[24] In the bulk payment environment, however, OCC failed to implement an appropriate process to account for adjusted claim submissions and make a correct adjustment, and instead OCC paid adjusted claims at the full amount, creating a duplicate payment.
2. TPAs submitted duplicate claims at the same-billed amount that were otherwise identical. The submission of unadjusted duplicate claims should have been prevented by TPAs' business processes and duplicate logic, but both TPAs identified flawed internal business processes and duplicate logic that led to duplicate claim submissions for unadjusted claims. Furthermore, OCC did not have effective processes in the bulk payment environment to properly detect unadjusted duplicate claims that were submitted with different PCNs.

Table 6. Summary of Duplicate Claims by Category

TPA	Adjusted Claims	Unadjusted Claims	Total Duplicate Payments
Health Net	54,885	87,608	142,493
TriWest	49,532	61,616	111,148
Total Duplicates	**104,417**	**149,224**	**253,641**

Source: VA OIG duplicate analysis of bulk payments made to Health Net and TriWest from March 4, 2016, through March 31, 2017, and analysis of FBCS payments made to Health Net and TriWest from November 1, 2014, through March 31, 2017. Duplicates were identified by matching claims paid in the bulk payment environment against each other in addition to claims paid in the FBCS environment for the identified periods above.

Background on Duplicate Payments

Prior to the initiation of the bulk payment process, FBCS and FSC claim reviewers would review each claim for potential duplicates when processed through FBCS individually and this process

[24] A PCN is a unique number assigned to each individual claim by the TPA prior to submission to OCC.

involved a review intended to prevent duplicate payment errors. In addition, claims processed in FBCS were routed through a tool used by OCC's Department of Program Integrity, referred to as the Program Integrity Tool (PIT), which reviewed the claims for potential duplicates prior to payment. However, processing claims individually through FBCS was time-consuming and resulted in a backlog of unpaid claims to TPAs. To make payments to TPAs faster and reduce this backlog, OCC implemented the bulk payment process, which removed the review of each individual claim when processed in FBCS with the intent of improving payment timeliness; however, OCC did not implement effective internal controls to detect the submission of duplicate claims by TPAs and prevent payment errors. Recommendation 1 in this report advises OCC to ensure duplicate claims are not submitted and paid.[25]

According to TPAs, duplicate payments primarily resulted from these issues:

True Duplicate Claims: Providers submitted multiple claims for the same service to TPAs. Each TPA stated that its duplicate logic did not consistently identify the claims as duplicates and made multiple payments to the provider. As a result, TPAs submitted multiple claims to OCC for the same service.

Void and Reissue: TPAs generated duplicate billings to OCC for various "void and reissue" circumstances, such as when the original payment was sent to the incorrect provider or address, a check was lost, or a check was stale. In these instances, the original check from the TPA to the provider was voided and reissued by the TPA, but the claims processing systems used by TPAs would automatically generate a duplicate claim to OCC, and OCC paid the TPA again.

Information Technology (IT): The IT systems used by Health Net caused duplicate billings to OCC. For instance, Health Net stated that it had a "system glitch" that caused duplicate claims with a sequential identifier to be submitted to OCC for the same service; the same claim was thus paid multiple times by OCC since it was not recognized as a duplicate.

Claims Submitted in Both FBCS and Bulk Payment Process: TriWest submitted claims for payment in both the FBCS and bulk payment processes, causing duplicate payments by OCC. TriWest attributed a portion of its errors to alleged guidance from OCC asking TriWest to submit all unpaid claims for payment under expedited modification, which included claims already submitted through FBCS for payment.

Adjusted Claims: Overpayments occurred when TPAs submitted an adjustment to a claim. According to both TPAs, they were instructed by OCC to include the full amount for the care without reducing the adjusted claim for amounts previously paid by OCC on the original claim. As a result, OCC paid the full amount of both the original and adjusted claim from TPAs.

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[25] According to OCC's Executive Director of Performance Improvement and Reporting, OCC in July 2017 began running all claims submitted through the bulk payment process through PIT to identify duplicate claims.

Claims Examiner Errors: Health Net attributed a portion of its overpayments to human error, which may include manually processing paper claims, or incorrectly making full payment on a resubmitted provider claim when a previously submitted claim had already been partially paid.

Duplicate Payments Arising from Adjusted Claims

The possibility of duplicate claims in the bulk payment environment was significantly increased because of OCC's method for processing adjusted claims received from TPAs. After providing services to a veteran under either a Choice or PC3 authorization, a provider sends a claim to the TPA for those services. Providers frequently submit to TPAs claims that contain charges greater than the applicable Choice or negotiated PC3 discounted rate. The TPA is obligated to determine the appropriate rate in compliance with the Choice or PC3 contract provisions, and to pay the provider and then bill VA according to the TPA contracts.

On occasion, a TPA will determine that it needs to resubmit charges for a claim that was previously submitted. In these situations, the TPA would resubmit a claim with an adjusted amount to OCC. A common scenario for a TPA resubmitting an adjusted claim to OCC is for reconsideration of charges previously billed on the initial claim. Both TPAs had established a process for flagging such adjusted Choice claims using a modifier to the PCN.

OCC had an established process with both TPAs in the FBCS environment to process adjusted Choice claims. OCC directed TPAs to resubmit adjusted claims for the full amount, rather than the balance due following the prior payment.[26] For example, if the TPA initially billed VA $100 for a veteran's care when the Medicare allowable reimbursement was $125, the TPA was instructed to submit a second claim for $125 to collect the $25 underpayment. Under OCC's prior FBCS payment process, the individual review process of each claim in FBCS would have identified the adjusted claim and only paid the adjusted $25 balance due. However, in the bulk payment environment, this resulted in both claims being paid—the first in the amount of $100 and the second in the full amount of $125, instead of the correct adjusted amount of $25.

According to TPAs, they anticipated that VA would be making the appropriate adjustment, so that only the additional $25 was paid. However, OCC staff acknowledged they did not develop a process to detect adjusted claims in the bulk payment environment, which resulted in significant duplicate payments for adjusted claims.

The OIG attributes overpayments for adjusted claims in the bulk payment environment to OCC's lack of controls to identify, calculate, and pay adjusted claims when processing bulk payments. In the bulk payment environment, OCC did not review each claim individually. Instead, OCC relied on a review process that only identified duplicate claims with identical PCNs or claim identification numbers. OCC's review failed to consider how to identify and process adjusted

[26] TPAs stated they were told by OCC to submit adjusted claims in the full amount so that VA would have the full history of the claim in its records—which OCC confirmed.

claims. When a TPA submitted a claim to OCC, rather than assigning a unique base PCN, the TPA would add a specific modifier to the PCN when invoicing to flag the claim as an adjusted claim. Each TPA used a slightly different protocol for modifying its PCN to submit an adjusted claim.

For example, TriWest simply modified its PCNs by adding an ascending increment, which was not always sequential, at the end of the base PCN. To distinguish Choice claims from PC3 claims, TriWest added CHO at the end of the PCN.

TriWest sent the following Choice claims to OCC for an ophthalmology exam that occurred on November 10, 2016. In the example below, the adjusted claim was a result of a change in the billed amount of $0.08 on the second claim to bill a current procedural terminology code on the claim at the correct Medicare rate.

Example of TriWest Adjusted Claim

Claim	PCN	Amount	OCC Received Claim
Original	163201853600CHO	$200.32	11/30/2016
Adjusted	163201853602CHO	$200.40	2/15/2017

Both claims were processed in the bulk payment environment and paid to the TPA in the full amount billed, rather than the second payment being the adjusted amount due of $0.08.

Health Net also modified its PCN when it sent an adjusted claim. Health Net uses modifier characters (such as ADJ for adjusted claim, RPR for reprocessed claim) following the base PCN.

Health Net sent the following Choice claims to OCC for an ophthalmology appointment that occurred on December 6, 2016. In the example below, the adjusted claim is a result of a change in the billed amount from $108.75 to $116.94, which appeared to re-bill the claim at the correct Medicare rate.

Example of Health Net Adjusted Claim

Claim	PCN	Amount	OCC Received Claim
Original	20161213P012364CHO	$108.75	2/3/2017
Adjusted	20161213P012364CHOADJ	$116.94	2/3/2017

Both claims were processed in the bulk payment environment and paid in the amount billed, for a total of $225.69, rather than the second payment being the additional $8.19 owed for a total of $116.94.

While OCC stated that its process detected duplicate claims submitted with an identical PCN in the bulk payment process, it did not account for adjusted claims submitted by TPAs with a

modified PCN. OCC's Program Management Officer of Claims Adjudication and Reimbursement stated that this was a significant flaw in its revised process for identifying duplicates in the bulk payment environment, and likely resulted in many duplicate payments. Approximately 41.2 percent of the duplicate claims the OIG identified were adjusted claims that were paid two or more times in the full amount billed, rather than the appropriate amount based on the adjustment.[27]

Duplicate Payments Arising from Void and Reissue

Both TPAs identified flawed internal processes that led to other kinds of duplicate payments. Each TPA relies on IT systems to manage the flow of claims data, and various deficiencies in these systems have led to duplicate claims being submitted to OCC.

One category of overpayment arising from duplicate claims is referred to as void and reissue. In some cases, it is necessary for TPAs to void payments to their network providers. These voids can occur when TPAs are informed the check was sent to the wrong address or payee (for example, sent to a facility as opposed to the physician), when the check has become stale, or many other scenarios. In most cases, a new check is issued by the TPA to the provider after the TPA voids the original check. Management officials at both TPAs acknowledged that their IT systems failed to suppress the reissued claims, which should not have been resubmitted to OCC for payment.

According to TPAs, as they issue a new check to providers, the IT systems used by TPAs automatically generate a new claim, which is then submitted to OCC with a different PCN. Because the claim arrives under a different PCN, OCC's duplicate review in the bulk payment environment failed to identify these claims as duplicates. Without an effective process to identify duplicate claims that have different PCNs, these new claims would not be identified by OCC as possible duplicates.

TPAs' Duplicate Logic Failed

The TPAs' network providers may bill the TPA more than once for the same episode of care. This repeated billing can be automatic and often occurs when the network provider has not received payment within a certain time frame. Management officials responsible for claims processing with each TPA acknowledged their duplicate logic failed to identify all provider duplicate claims, which subsequently resulted in duplicate claims submitted to OCC for payment. For example, TriWest sent the following claims to OCC for psychotherapy appointments that occurred from July 1 through October 21, 2016:

[27] In July 2017, OCC began using PIT to identify and prevent payment of duplicate claims (including adjusted claims) on a prepayment basis in the bulk payment environment.

Example of TriWest Duplicate

Claim	PCN	Amount	OCC Received Claim
Original	170191561400CHO	$758.16	3/10/2017
Duplicate	170192241300CHO	$758.16	3/10/2017

Both claims had been assigned unique PCNs, even though the claims submitted by the network provider were identical. TriWest acknowledged that the provider submitted the same claim twice, but its subcontractor's duplicate logic failed to identify the relationship between the two claims, resulting in the TPA submitting two separate but identical claims to OCC, each with a unique PCN.[28]

Health Net's duplicate logic also failed to identify all duplicate claims from providers, and it sent the following claims to OCC for a physical therapy appointment that occurred on January 26, 2017, also with different PCNs:

Example of Health Net Duplicate

Claim	PCN	Amount	OCC Received Claim
Original	20170216P014155CHO	$107.24	2/24/2017
Duplicate	20170216P013954CHO	$107.24	2/24/2017

Effect of Duplicate Payments

As a result of ineffective internal controls designed to detect duplicate claims, TPAs submitted and OCC paid TPAs about $66.1 million in duplicate claims from March 4, 2016, through March 31, 2017, in the bulk payment processing environment.

For purposes of calculating and presenting these duplicate payments, the OIG segregated duplicate payments into two categories: Duplicate Payments Resulting from Adjusted Claims and Duplicate Payments Resulting from Unadjusted Claims. Table 7 summarizes the dollar amounts of these overpayments by error type and TPA.

Table 7. Summary of Duplicate Payment Dollars

TPA	Duplicate Payments Resulting from Adjusted Claims	Duplicate Payments Resulting from Unadjusted Claims	Total Duplicate Payments
Health Net	$23,398,928	$8,677,472	$32,076,400
TriWest	$18,324,973	$15,723,061	$34,048,034

[28] TriWest used a subcontractor, Wisconsin Physicians Service, to adjudicate and process claims on its behalf.

Total Duplicates	$41,723,901	$24,400,533	$66,124,434

Source: VA OIG duplicate analysis of bulk payments made to Health Net and TriWest from March 4, 2016, through March 31, 2017, and analysis of FBCS payments made to Health Net and TriWest from November 1, 2014, through March 31, 2017. Duplicates were identified by matching claims paid in the bulk payment environment against each other in addition to claims paid in the FBCS environment for the identified periods.

Conclusion

OCC paid duplicate claims improperly submitted by TPAs because OCC had ineffective controls to prevent duplicate claims. OCC's lack of proper internal controls in the bulk payment process to prevent duplicate payments resulted in overpayments of $66,124,434 to TPAs. In the OIG's audit work and in correspondence and other communications with VA, the two TPAs have acknowledged both receiving overpayments from VA and their obligation to repay all such overpayments.[29]

VA is currently working closely with the OIG, VA's Office of General Counsel, and other relevant government authorities to implement a process to ensure that such overpayments will be recovered. To date, VA has received nearly $41 million in reimbursement from Health Net for Choice claim overpayments from the bulk payment environment.[30]

Recommendations 1–2

1. The Executive in Charge, Office of the Under Secretary for Health, continue to support processes to prevent duplicate payments made to third-party administrators through the bulk payment process and ensure that proper controls are in place to prevent duplicate payments to third-party administrators through all other current payment methodologies and under future Community Care contracts.

2. The Executive in Charge, Office of Under Secretary for Health, 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 of overpayments by the third-party administrators.

Management Comments and OIG Response

The Executive in Charge, Office of the Under Secretary for Health, concurred with the OIG findings and recommendations. The Executive in Charge provided acceptable action plans for both recommendations.

[29] See *Accuracy and Timeliness of Payments Made Under the Choice Program Authorized by the Veterans Access, Choice, and Accountability Act*, September 12, 2017, www.va.gov/oig/pubs/admin-reports/VAOIG-17-00000-379.pdf

[30] OCC's Executive Director, Performance Improvement and Reporting, confirmed that Health Net reimbursed $40,802,937.55 for Choice claim overpayments on April 13, 2018.

To address Recommendation 1, the Executive in Charge reported that OCC and FSC are performing claims reviews to assess payment accuracy. The Executive in Charge reported that OCC uses its Program Integrity Tool to identify and prevent duplicate payments prior to payment in the expedited environment. The Executive in Charge also reported that FSC's Choice Claims Adjudication system is used to evaluate most Choice claims for duplicates prior to payment. In addition, the Executive in Charge reported that future TPAs will hire an independent third-party auditor to ensure payment accuracy.

To address Recommendation 2, the Executive in Charge reported that 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 and to ensure the overpayment matters are fully resolved.

The OIG will monitor VHA's progress and follow up on the implementation of the recommendations until all actions are completed.

Finding 2: Other Payment Errors Were Made on an Additional 10 Percent of Bulk Payments

From March 4, 2016, through March 31, 2017, the OIG estimated that OCC made other payment errors on 10 percent of payments submitted by TPAs in the context of bulk payments. The OIG also identified these types of errors in a recently released FBCS Payment audit report.[31] These errors fell into three categories:

Payment Rate: Payments made on claims that did not use the appropriate Medicare or contract adjusted rate.

Other Health Insurance: Payments made on Choice claims that were not adjusted for the amount OHI was responsible to pay the provider.

Pass-through: Payments made on Choice claims where OCC reimbursed the TPA more than the TPA paid the provider.

As the OIG described in its FBCS Payment report, these errors occurred because OCC did not design effective payment and internal control processes for Choice that would prevent payment of improper claims submitted by TPAs. OHI and Pass-through requirements were not applicable to PC3 claims; however, the PC3 Lump Sum claims had no review for payment rate accuracy via the bulk payment process and were thus affected by this lack of internal controls. Because OCC failed to design an effective system of internal controls for the bulk payment processing environment, it overpaid TPAs about $35.3 million attributable to these three error types, from March 4, 2016, through March 31, 2017.

OCC Made Bulk Payment Errors

The OIG estimated that OCC made these categories of payment errors on about 479,500 of 4.8 million claims (10 percent) submitted by TPAs in the bulk payment environment paid from March 4, 2016, through March 31, 2017.

[31] *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (Report No. 15-03036-47, December 21, 2017).

Table 8 summarizes estimates of payment errors grouped in three categories.

Table 8. Estimate of Payment Errors by Type of Error*

TPA	Payment Rate	OHI	Pass-through	Total Errors
Health Net	36,800	147,000	-	183,800
TriWest	273,000	-	22,700	295,700
Total Errors	**309,800**	**147,000**	**22,700**	**479,500**
Percentage of Error	6.5%	3.1%	0.5%	10%

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017
**Table contains rounded projected estimates. The total percentage of error is rounded to the nearest whole percentage.*

Payment Rate Errors

As discussed in the FBCS Payment report, OCC's Director of Claims Adjudication and Reimbursement informed the OIG that OCC relied on TPAs to ensure Choice claims were billed at the correct Medicare rate and did not verify that TPAs billed at the correct rate prior to paying claims. The same is true in the bulk payment environment: OCC paid the amount TPAs billed on the claims submitted for bulk payment without validating the rate charged.

To determine whether TPAs billed and OCC paid the correct contract rate, the OIG used a contractor that specializes in processing medical claim payments to identify a Medicare rate for each claim in the selected sample. The OIG then applied the applicable percentage of the Medicare rate, per the PC3 or Choice contract terms, to determine the allowable contract rate. If there was no established Medicare rate, the OIG used the applicable VA Fee Schedule. The OIG compared the contract rate to the paid amount to determine the Payment Rate errors. The OIG estimated that Payment Rate errors occurred for about 309,800 of 4.8 million medical claims (7 percent) paid through the bulk payment process from March 4, 2016, through March 31, 2017, resulting in approximately $18.3 million in overpayments to TPAs.

OHI Payment Errors

Until it was amended in April 2017, VACAA, as well as the TPA contracts, required providers to bill a veteran's OHI prior to the TPA invoicing OCC for nonservice-connected care.[32] After OHI paid its portion of the care, TPAs sent a claim to OCC for remaining costs, up to the Medicare rate allowed under the provisions of the Choice-specific modification, which were not covered

[32] VACAA, as amended, imposed on the VA primary payment responsibility for services provided after April 19, 2017. This amendment requires that VA pay for care and pursue recovery of payment by OHI directly, rather than requiring TPAs to do so. The PC3/Choice Program contracts were amended accordingly.

by OHI. If the care was service-connected, or the veteran was nonservice-connected and did not have OHI coverage, the TPA would bill OCC for the full services provided.

To determine whether OHI was billed as the primary payer for the Choice payments in the selected sample, the OIG reviewed each claim and compared it to the veteran's electronic health record to determine whether the service was for nonservice-connected care. Then, in each instance in which the OIG identified the care was for nonservice-connected care, the OIG reviewed the veteran's registration data to determine whether the veteran had OHI coverage. The OIG identified OHI-related payment errors in its sample by reviewing OCC payment data, Electronic Data Interchange claims received, and TPA remittance advice.[33] These errors occurred when OCC was paying claims submitted by 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.

The OIG estimated that OCC paid Health Net approximately $48.3 million on about 147,000 claims when the veterans' OHI should have been billed as the primary payer. The OIG estimated that $16.8 million of the $48.3 million paid by OCC would have been recovered from veterans' OHI, based on VA's Medical Care Collection Fund's (MCCF) March 2017 third-party collections to billing percentages of 34.8 percent. 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 collections from the insurers. It thus provides a reasonable benchmark for the amount OCC would expect to recover if it sought payment from OHI carriers for services provided under Choice. The OIG did not identify any errors by TriWest in this error category within the selected sample population.

Pass-through Errors

As explained in the FBCS Payment report, the PC3 contracts contained no language that prevented TPAs from negotiating reimbursement rates with their providers at discounts below Medicare rates. 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.

[33] The Electronic Data Interchange is a mechanism described in the contracts with TPAs that requires TPAs to submit their invoices via a Health Insurance Portability and Accountability Act-compliant Electronic Data Interchange transaction.

When OCC modified the PC3 contracts in October 2014 to include Choice, the following language was added to the contract:

> The contractor shall not negotiate discounts off the Medicare rate with providers who 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 TPAs' ability to retain the price difference between what OCC paid TPAs for medical services and the amount TPAs reimbursed providers for any services under the Choice portion of the contract. However, TPAs interpreted the contract as allowing them to send Choice patients to their PC3 network providers who had negotiated rates below Medicare rates, while billing OCC at 100 percent of the Medicare rate. OCC modified the original Pass-through language on September 17, 2015, as indicated below [emphasis added], to clarify the definition of "pass through."

> The contractor shall not negotiate discounts off the Medicare rate with providers who 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 [Contract Line Item Number], **up to 100% of Medicare.**

Both OCC and TPAs appear to have interpreted it to mean that Choice claims, billed from a provider in both the PC3 and Choice networks after the modification, were required to be billed at the rate paid to the provider by TPAs. This would prevent TPAs from retaining any of the negotiated savings under a PC3 network agreement between TPAs and the provider. In other words, the amount paid to the provider and the amount billed to OCC for a Choice claim had to be the same. The OIG considered a Pass-through error to be when OCC reimbursed TPAs for a Choice claim more than TPAs paid the provider after the contract was modified in September 2015. To identify Pass-through errors, the OIG collected copies of the remittance advice for each of the claims in its sample from TPAs to determine what they paid the providers. The OIG then compared the amounts TPAs paid their providers to the amounts OCC paid TPAs, and determined the payments were in error when TPAs paid the providers less than they billed OCC for the same treatment.

In the context of the bulk payment environment, the OIG did not find any Pass-through errors on the part of Health Net in the selected sample. The OIG identified a small number of Pass-through errors by TriWest in the context of the PC3 Lump Sum universe, when TriWest had incorrectly identified Choice claims as PC3 claims. Because TriWest processed these claims as PC3 claims, it did not pass through the discounts from the provider to OCC, which would be required for Choice claims.

The OIG thus estimated that OCC reimbursed TriWest more than TriWest paid providers for about 22,700 of 4.8 million medical claims (0.4 percent) paid through the bulk payment process

from March 4, 2016, through March 31, 2017. These Pass-through errors resulted in an estimated $0.2 million in overpayments to TriWest.

Causes of Bulk Payment Errors

The FBCS Payment report details the internal control weaknesses that contributed to payment errors in the FBCS environment.[34] In summary, the OIG concluded that OCC did not follow these internal control principles identified in the Government Accountability Office's *Standards for Internal Control in the Federal Government*:

- Create clear written policy to establish and 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 overpaying medical claims.
- Establish monitoring activities to ensure internal controls are working.

Weak Payment Controls Resulted in Overpayments of $35.3 Million

In addition to the duplicate errors described in Finding 1, the OIG estimated that OCC made approximately 479,500 bulk payment errors from March 4, 2016, through March 31, 2017. These payment errors resulted in an estimated overpayment to TPAs of about $35.3 million for this period. Table 9 summarizes the estimated effect of overpayments by error type.

Table 9. Estimated Monetary Effect of Payment Errors

TPA	Payment Rate	OHI*	Pass-through	Total
Health Net	$7.1 million	$16.8 million	N/A	$23.9 million
TriWest	$11.2 million	N/A	$0.2 million	$11.4 million
Total	**$18.3 million**	**$16.8 million**	**$0.2 million**	**$35.3 million**

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017
** The OIG estimated $16.8 million of the $48.3 million paid by OCC would have been paid by the veteran's OHI based on VA's Medical Care Collection Fund's March 2017 third-party collections to billing percentage of 34.8 percent.*[35]

[34] *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (Report No. 15-03036-47, December 21, 2017), pp. 20–24.

[35] The actual amount of OHI payment errors in the OIG sample universe cannot be determined without evidence of what would have been paid by the veterans' OHI as the primary payer for each claim.

Conclusion

In its FBCS Payment report, the OIG identified these same error types; the OIG attributed the causes of the errors discussed in this finding to the same lack of internal controls over the payment process. In that report, the OIG made these six recommendations to the Executive in Charge, Office of the Under Secretary for Health:

1. Develop and issue written payment policies to guide staff processing medical claims received from TPAs, as well as establish expectations and obligations for TPAs that submit invoices for payment.
2. Ensure payment processing staff have access to documentation from TPAs verifying amounts paid to providers to ensure TPAs are not billing VA more than they paid the provider for medical claims.
3. Ensure VHA payment staff has access to accurate data regarding veterans' other health insurance coverage and establish appropriate processes for collecting payments from these health insurers.
4. Ensure the new payment processing systems used for processing medical claims from TPAs have the ability to adjudicate reimbursement rates accurately.
5. Ensure VA performs post-payment audits on a periodic basis to determine if payments made to TPAs for medical care are accurate.
6. Ensure that 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.

The OIG is confident that once VHA implements these prior recommendations, it will reduce the risk of payment errors. The Executive in Charge, Office of the Under Secretary for Health, anticipates all recommendations to be implemented by December 2018. The OIG therefore makes no further recommendations.

Appendix A: Background

PC3 and Choice Eligibility

The PC3 contracts allowed VA to offer non-VA health care to veterans when the care is unavailable with the VA medical facility; or due to long wait times, geographic inaccessibility, or other factors.

Following the enactment of Choice, OCC began processing claims at a centralized location for Choice care, using FBCS, implemented via a service level agreement with FSC. VACAA (as amended) requires veterans enrolled in VA's healthcare 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 or less than 40 miles from the VHA medical facility and must travel by air, boat, or ferry or faces an unusual or excessive burden to reach such a facility
- Resides in a state without a VHA medical facility that provides hospital care, emergency medical services, and complex surgical care

Parties Involved in Bulk Payments of PC3 and Choice Claims

Parties involved in the bulk payment process include:

Office of Community Care: OCC provides program direction and oversight over the PC3 and Choice Programs. OCC represents a single accountable authority for development of the administrative processes, policies, regulations, and directives associated with the delivery of VA health benefits 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 in the PC3 and Choice Programs, related to non-VA care. OCC's Department of Program Integrity provides oversight of OCC programs. In July 2017, OCC implemented prepayment controls to analyze and prevent duplicate claims prior to payment for claims processed under the expedited modifications. According to OCC, to date, its prepayment controls have resulted in cost avoidance of about $71 million in potential duplicate payments.

Financial Services Center: FSC was not involved in the prepayment review or payment of bulk claims. However, FSC is in the process of performing a post-payment rate review of claims paid via bulk payments. The OIG noted that FSC is currently under a service level agreement with OCC to provide Choice claims processing services. FSC processed claims

prior to bulk payments via the FBCS process and is currently processing claims using Plexis Claims Manager (PCM), a new claims payment process.

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 nonservice-connected care at the rates negotiated in accordance with VACAA or PC3. TPAs are responsible for paying community providers prior to submitting claims to OCC for payment.

Wisconsin Physicians Service (WPS): WPS is a subcontractor to TriWest that processes claims on behalf of TriWest. VA does not have a contractual relationship with WPS. Therefore, TriWest has the responsibility to ensure WPS adjudicates and processes claims in accordance with the contract between TriWest and VA.

Providers: Providers are defined in the contract as a hospital, clinic, healthcare institution, healthcare professional, or group of healthcare professionals who provide healthcare services to veterans. Providers are responsible for billing OHI before submitting claims. Providers submit claims to and receive payment directly from TPAs. To participate in the Choice or PC3 networks, providers enter into agreements with TPAs.

Claims Paid in Bulk Payments

From March 4, 2016, through March 31, 2017, OCC paid about 4.8 million claims for about $1.65 billion in payments to TPAs. OCC initiated contract modifications to the PC3/Choice Program contracts with Health Net and TriWest to enable the payment of large numbers of claims in the aggregate without the usual manual prepayment processing.

Table 10 provides the timeline of these contract modifications.

Table 10. Timeline of Contract Modifications

Effective Date	TPA	Mod*	Effect
3/4/2016	TriWest	20	Lump Sum: Processed all unpaid PC3 claims with dates of service prior to January 1, 2016.
3/21/2016	Health Net	20	VCPBYPASS: Processed Choice claims that were not previously submitted to VA due to missing medical documentation with dates of service from the inception of Choice through March 31, 2016.
3/21/2016	TriWest	21	VCPBYPASS: Processed Choice claims that were not previously submitted to VA due to missing medical documentation with dates of service from the inception of Choice through March 31, 2016.
6/16/2016	TriWest	27	Lump Sum: Revised language of Mod 20 to state that VA will identify which PC3 medical claims will be included in the lump sum payments. Mod continued to process all unpaid PC3 claims with dates of service prior to January 1, 2016.
10/7/2016	Health Net	30	Expedited: Processed on a recurring basis Choice claims with date of claim receipt through November 15, 2016.
11/2/2016	TriWest	33	Expedited: Processed on a recurring basis Choice claims submitted to VA up to the transition to the PCM claims processing system.[36]
11/15/2016	Health Net	33	Expedited: Extended the date of Mod 30 to the implementation date of PCM claims processing system.

Source: Contracts with Health Net (VA791-13-D-0053) and TriWest (VA791-13-D-0054)
**Mod=modification*

[36] In February 2017, FSC began using new medical claims adjudication software, PCM, 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. Claims relating to services prior to these dates continue to be processed through the Expedited process described herein, and this process will continue until all such claims have been processed. PCM was implemented to replace the FBCS and bulk payment process under a service level agreement between FSC and OCC. This payment process with PCM will be the subject of a future audit.

Under these modifications, OCC issued bulk payments for medical care authorized by both the PC3 and Choice Programs. Bulk payments fell in one of three categories:

- PC3 Lump Sum: Issued to TriWest for PC3 claims with dates of service prior to January 1, 2016
- VCPBYPASS: Issued to address payment backlog on Choice claims because of a medical documentation requirement
- Expedited: Issued on a recurring basis to address backlogged Choice claims that were pending submission to or payment from VA during the transition period from FBCS to the FSC's PCM system

Appendix B: Scope and Methodology

Scope

The OIG performed its audit from April 2017 to May 2018 to determine the accuracy of PC3 and Choice payments in the bulk payment environment. The audit included PC3 and Choice claims processed via the bulk payment process from March 4, 2016, through March 31, 2017. The OIG did not audit PC3 or Choice medical payments processed in FBCS, Choice administrative payments, or payments for Hepatitis C and other non-VA care that used Choice funding.

Methodology

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

PC3 and Choice payment data were obtained from the Fee Payment Processing System. For the duplicate payment review, the OIG developed data analytic tools to compare the paid claim to other paid claims in the universe to identify the universe of duplicate claims, which included matching claims paid in the bulk payment environment against claims paid in the FBCS process. For the review of Payment Rate accuracy, authorization, OHI, and Pass-through, the OIG reviewed a statistical sample of 145 paid claims within the bulk payments universe. Appendix C contains details of the statistical sampling methodology.

To determine payment rate accuracy, the OIG reviewed each sample by comparing the amounts paid for each current procedural terminology code either to the Medicare Reimbursement rate or to the VA Fee Schedule rate when there was not an established Medicare rate. To determine whether PC3 or Choice payments were correctly authorized, the OIG searched each veteran's electronic health record for the VA Form 10-0386 or a consult related to the episode of care.[37] To determine if VA has primary or secondary payment responsibility for Choice claims, the OIG reviewed the VA's electronic health records and VistA records. For the Pass-through review, the OIG collected copies of the remittance advice for each of the claims in the sample from TPAs to determine what TPAs paid the providers and compared it to the amount OCC paid.

To aggregate and estimate an overall rate of these kinds of payment errors, the OIG created an error hierarchy, to establish a methodology for determining a category in which to report a payment error when the sample item fell into more than one category.[38] To categorize the

[37] VA Form 10-0386 is a VHA Choice Approval for Medical Care form, which allows an authorized VA representative to confirm that a veteran is eligible for Choice.

[38] Payment Rate, OHI, and Pass-through error estimates are based on a statistical projection, in contrast to Finding 1 where data analytics were applied to the universe of paid claims to identify duplicate overpayments.

payment processing errors so the OIG did not double count errors that occurred in multiple categories, it used this hierarchy: Pass-through errors, then Payment Rate errors. The OIG counted OHI errors independently because OHI errors would be recoverable from a veteran's OHI and be subject to adjustment if paid as a Pass-through error or Payment Rate 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 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 provider claim and remittance advice information provided by TPAs

Data Reliability

To test the reliability of computer-processed data, the OIG extracted PC3 and Choice paid claims for each type of bulk payment from March 4, 2016, through March 31, 2017. The OIG performed the following steps for 145 claims from its statistical sample:

- The OIG independently queried bulk payments universe data and identified key fields (veteran last name, Social Security number, treatment date, current procedural terminology code, disbursed amount for each sample item).
- The OIG compared the key fields on medical claims submitted via Electronic Data Interchange by TPAs to OCC. The OIG further compared the key fields on medical claims submitted by providers to TPAs. The OIG concluded the data were valid and sufficiently reliable to support the audit's objective and conclusions.

Government Standards

Our assessment of internal controls focused on those controls relating to our audit objective. 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 of PC3 and Choice payments made under bulk payments, the OIG sampled paid claims for Health Net and TriWest from March 4, 2016, through March 31, 2017.

Population

The OIG identified 4,758,759 paid claims that resulted in $1,646,398,735 of PC3 and Choice bulk payments for the period from March 4, 2016, through March 31, 2017.

Sampling Design

The OIG divided its population into three strata. For each TPA, Health Net and TriWest, the OIG stratified by the type of claim, either PC3 or Choice. Table 11 describes the total sample items for each category.[39]

Table 11. Sample Size by Stratum

Category	Stratum	Total Sample
Health Net - Choice	Stratum 1	70
TriWest - Choice	Stratum 2	45
TriWest - PC3	Stratum 3	30
Total		**145**

Source: VA OIG sample size by stratum determined by OIG statistician

Weights

The OIG calculated all estimates in this report using weighted sample data. Weighted sample data are 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, the OIG 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.

[39] No Health Net PC3 claims were paid via bulk payment.

Projections and Margins of Error

The point estimate (estimated error) is a parameter of a numerical value of the estimator obtained by the sample selected. The margin of error is the measure of precision of the point estimate for the sample selected. 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 the OIG 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 14 show the error rates and estimates based on the OIG's analysis of sample items. For some attributes the OIG 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%
Health Net				
Payment Rate Errors	36,771	60,880	1	97,651
OHI Errors	147,083	119,083	28,000	266,167
Pass-through Errors	-	-	-	-
TriWest				
Payment Rate Errors	273,132	173,809	99,323	446,941
OHI Errors	-	-	-	-
Pass-through Errors	22,719	15,618	7,100	38,337
Weighted Estimate for Health Net and TriWest				
Payment Rate Errors	309,903	184,163	125,740	494,066
OHI Errors	147,083	119,083	28,000	266,167
Pass-through Errors	22,719	15,618	7,100	38,337

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017

Table 13. Estimated Percentage of Payment Errors

TPA	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net				
Payment Rate Errors	1.4	2.4	< 0.01	3.8
OHI Errors	5.7	4.6	1.1	10.3
Pass-through Errors	-	-	-	-
TriWest				
Payment Rate Errors	12.5	8.0	4.6	20.5
OHI Errors	-	-	-	-
Pass-through Errors	1.0	0.7	0.3	1.8
Weighted Estimate for Health Net and TriWest				
Payment Rate Errors	6.5	3.9	2.6	10.4
OHI Errors	3.1	2.5	0.6	5.6
Pass-through Errors	0.5	0.3	0.2	0.8
Total Errors	10.1	4.6	5.5	14.7

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017

Table 14. Estimated Dollar Amount of Payment Errors*

TPA	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net				
Payment Rate Errors	$7,138,691	$11,819,212	$194	$18,957,903
Pass-through Errors	-	-	-	-
TriWest				
Payment Rate Errors	$11,167,155	$9,388,248	$1,778,908	$20,555,403
Pass-through Errors	$154,531	$139,211	$15,320	$293,742
Weighted Estimate for Health Net and TriWest				
Payment Rate Errors	$18,305,847	$15,094,137	$3,211,710	$33,399,984
Pass-through Errors	$154,531	$139,211	$15,320	$293,742
Total Errors	$16,811,974	$15,923,339	$888,634	$32,735,313

Source: VA OIG payment error projections based on a sampled universe of PC3 and Choice claims paid via the bulk payments process for the period from March 4, 2016, through March 31, 2017

** Projected amount for OHI errors was not estimated because the data lacked Explanation of Benefits documenting the exact amount OHI would have paid for the medical services provided, which is necessary to determine the accurate amount of insurance reimbursement for each claim.*

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Finding	Explanation of Benefits	Better Use of Funds *(in millions)*	Questioned Costs *(in millions)*
1	Implement internal controls to detect duplicate payments	$0	$66.1
2	Implement internal controls to detect all other payment errors. (Questioned costs consist of payments made that did not meet the PC3/Choice Program contracts payment criteria. See note below.)	$0	$35.3*
	Total	**$0**	**$101.4**

Note: The OIG considered the approximate $101.4 million in questioned costs to be improper payments. Office of Management and Budget 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.

**$16.8 million of the $35.3 million questioned cost is based on estimated insurance reimbursements calculated using MCCF's March 2017 third-party collections to billing percentage of 34.8 percent.*

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: July 18, 2018

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

Subj: OIG Draft Report, Veterans Health Administration: Bulk Payments Made Under Patient-Centered Community Care/Veterans Choice Program Contracts (VIEWS 00080113)

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

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report Veterans Health Administration (VHA): Bulk Payments Made Under Patient-Centered Community Care/Veterans Choice Program Contracts. I concur with OIG's report as written and provide a reply to recommendations 1 and 2.

2. In January 2017, based on an internal audit of a form of bulk payments (PC3 lump sum payments), VHA Office of Community Care (OCC) recognized duplicate payments as concern and used its data analytics tool (the Program Integrity Tool) to conduct a thorough analysis of Choice bulk payments for duplicates leading to more than $80 million of identified potential overpayments that were shared with HealthNet and TriWest in July 2017.

3. Recognizing the impact of duplicate payments in the bulk payment environment, VHA OCC then incorporated the use of the Program Integrity Tool prior to payment of claims. This has been in place for nearly a year (since July 2017) and, to date, has prevented over $71 million in potential overpayment.

a. It is important to note that the sample used in the OIG's bulk payment audit only included claims prior to the start of this process over 1 year ago.

4. As the Choice Program matured, our processes for payment have as well, and most of current Choice claims are now processed through the Financial Services Center's Choice Claims Adjudication system, an auto-adjudication system that incorporates strong internal controls as part of the payment process. Choice claims are evaluated for duplicates prior to payment in this system and additional controls include evaluation of claims pricing in accordance with Choice contracted rates prior to payment.

5. VHA OCC and the Department of Veterans Affairs (VA) Office of General Counsel continue to cooperate fully with the VA OIG and all relevant government agencies in the review and determination of an appropriate process for reimbursement of overpayments by the Third-Party Administrators. As noted in the OIG's report, $40 million has been successfully recovered through this process to date.

6. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(Original signed by)

Carolyn M. Clancy, M.D.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Veterans Health Administration: Bulk Payments Made Under Patient-Centered Community Care/Veterans Choice Program Contracts

Date of Draft Report: June 28, 2018

Recommendations/Actions	**Status**	**Target Completion Date**

Recommendation 1. We recommend that the Executive in Charge, Office of the Under Secretary for Health, continue to support processes to prevent duplicate payments made to Third Party Administrators (TPAs) through Bulk Payment processes and ensure that proper controls are in place to prevent duplicate payments to TPAs through all other current payment methodologies and under future Community Care contracts.

VHA Comments: Concur. At present, the Veterans Health Administrations (VHA) Office of Community Care (OCC) and the Financial Services Center (FSC) are performing claims reviews (including those for duplicate payments) to assess payment accuracy:

- In January 2017, the Department of Veterans Affairs (VA) noted in the Office of Inspector General's (OIG) report, VHA OCC's internal audit team presented results to OCC leadership from an internal audit that indicated duplicate payments to Third Party Administrators (TPA) were an area of concern. Using 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. To date, use of the PIT has prevented over $71 million in potential overpayments. OCC runs a bi-weekly report to assess duplicate payment identified by the PIT tool.
- As the Choice Program matured, our processes for payment have as well, and most of current Choice claims are now processed through the FSC's Choice Claims Adjudication (CCA) system, an auto-adjudication system that incorporates strong internal controls as part of the payment process. Choice claims are evaluated for duplicates prior to payment in this system and additional controls include evaluation of claims pricing in accordance with Choice contracted rates prior to payment.

Moving forward, The Community Care Network (CCN) Request for Proposals (RFP) mandates that future 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.

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

- CCN RFP Requirements related to payment accuracy controls
- Example of bi-weekly report used to assess duplicate payment activity

Status: In Progress

Target Completion Date: December 2018

Recommendation 2. We recommended the Executive in Charge, Office of Under Secretary for Health, 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 of overpayments by the TPAs.

VHA Comments: Concur. VHA's Office of Community Care will continue to work collaboratively with the VA Office of General Counsel, OIG, and all relevant government authorities to pursue an appropriate reimbursement process for identified Choice overpayments and to ensure that overpayment matters are fully resolved. As noted in the OIG's report, $40 million has been successfully recovered to date.

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, OCC will continue to fully comply with all requests from the VA OIG and other relevant government authorities.

Status: In Progress

Target Completion Date: TBD

(date for this action will be determined by VA OIG)

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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