DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System

AUDIT | REPORT #19-00226-245 | SEPTEMBER 30, 2020

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to determine whether the VA Office of Community Care accurately reimbursed healthcare claims paid under the Veterans Choice Program to third-party administrators for care that veterans received from community providers. This is the third OIG report on claims payments under the Choice program, which ran from 2014 to 2019.[1] This report focuses on claims processed through the Plexis Claims Manager system that were paid from February 21, 2017, through December 31, 2018.

VA amended its Patient-Centered Community Care (PC3) contracts to implement the Choice Program. Although the Choice program ended on June 6, 2019, the Office of Community Care continues to process PC3 claims under a PC3/Choice contract through the Plexis Claims Manager system. The Office of Community Care has processed approximately $4.2 billion in PC3 healthcare claims payments from October 1, 2019, through April 30, 2020.

The PC3/Choice contract outlines a specific reimbursement hierarchy consisting first of Medicare fee schedule rates. Then, if no Medicare rate is available, the local VA fee schedule should be used, followed by reimbursement at a verifiable usual and customary rate if no Medicare or VA fee schedule rate is available.[2] Usual and customary rates reflect what other payers typically reimburse to providers in the same geographic area for the same or similar medical services.

The audit team concluded that overpayments would continue unless the Office of Community Care implements policies that define usual and customary rates and controls that ensure payments are processed in accordance with the terms of the PC3/Choice contract, and eliminates reimbursements at "billed charges."[3] Future community care programs need to ensure they have established reimbursement methodologies for claims that do not have a Medicare or VA fee schedule rate to limit overpayments that would result from reimbursing third-party administrators at "billed charges."

[1] The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (August 7, 2014) was the founding legislation for the Veterans Choice Program. The program's sunset date was June 6, 2019, in accordance with the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act). Following the sunset of the Veterans Choice Program, VA is transitioning to new Community Care Network contracts. More information is in appendix A.

[2] The VA fee schedule amount is determined by analyzing provider billings within specific localities, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA fee schedule amount is the charge falling at the 75th percentile.

[3] "Billed charges" refers to VA reimbursing the third-party administrator at the same amount the third-party administrator billed VA.

The Office of Community Care had not ensured there were complete payment rate schedules or guidance to appropriately enforce Choice contract payment methodology and prevent overpayments through sufficient oversight. This oversight would include formal written guidance provided to the VA Financial Services Center or comprehensive audits performed by the Office of Community Care, which would be independent of the VA Financial Services Center's internal review of its own work.

Previous OIG audits of payments on Choice contracts found millions of dollars in payment errors to third-party administrators:

- *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (December 2017): The OIG estimated $39 million in payment errors to third-party administrators for claims processed from November 1, 2014, through September 30, 2016.[4]
- *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts* (September 2018): The OIG estimated $101 million in payment errors to third-party administrators for claims that were paid from March 4, 2016, through March 31, 2017.[5]

Such payment errors reduce the funding available for veterans to receive medical care from non-VA providers.

What the Audit Found

The OIG found that the Office of Community Care reimbursed third-party administrators for healthcare claims at rates higher than typical for the same or similar medical services in a given geographic area.

This occurred because the Office of Community Care did not establish payment controls such as using verifiable usual and customary rates to avoid reimbursing third-party administrators at "billed charges." Instead, the Office of Community Care paid an estimated 1.1 million (about 13 percent) of 8.6 million outpatient Choice claims processed from February 21, 2017, through December 31, 2018, in the Plexis Claims Manager system at rates higher than what could be considered usual and customary. The audit team estimated that the Office of Community Care could have saved about $132.1 million if its leaders had established clearly defined usual and customary rates and established payment controls to use these rates when processing claims for reimbursement to third-party administrators in the Plexis Claims Manager system.

[4] VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, 15-03036-47, December 21, 2017.

[5] VA OIG, *Audit of Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, 17-02713-231, September 6, 2018.

During the audit, the team questioned several senior Office of Community Care officials about the Choice contract's definition of usual and customary rates. The Office of Community Care interpreted usual and customary rates to mean "billed charges." The audit team also asked the Office of Community Care about the reasonable charges schedule used by the office's Revenue Operations division, which is the rate schedule VA uses to bill third-party insurance for VA services. Office of Community Care officials from the Policy and Planning and the Payment Operations and Management divisions used "billed charges" instead of the Revenue Operations division's reasonable charges schedule as a basis for usual and customary rates. In addition, no legal opinion by the Office of General Counsel or other support for this interpretation was provided by the Office of Community Care. The Office of Community Care's failure to establish a basis for usual and customary rates and implement the required contract reimbursement methodology significantly contributed to the office's inability to reduce program costs.

The OIG also found that the Office of Community Care has not fully implemented prior OIG recommendations and developed effective payment and internal control processes for the Choice program. The OIG estimates the office made about $73 million in erroneous payments for Choice outpatient claims to third-party administrators as a result for two types of errors:

- **About $72.4 million in payment-rate errors.** Payment-rate errors occurred when the payments did not have the appropriate Medicare or contract-adjusted rate.
- **Approximately $586,000 in pass-through payment errors.** Pass-through errors occurred when third-party administrators billed, and VA reimbursed, more than the third-party administrators paid the provider.

The OIG found that the Office of Community Care did not ensure that payment-rate schedules were current, accurate, and complete to prevent overpayments. The office also did not develop standard operating procedures for third-party administrators or its own claims processing staff for the Choice program.

What the OIG Recommended

The OIG made eight recommendations to the deputy under secretary for health for the Office of Community Care related to the management of claims payments, including creating a formal policy and a master usual and customary rate schedule for community care claims that would be provided to parties responsible for reimbursing them. They also included defining usual and customary charges billed to third-party payers for PC3/Choice contract claims and ensuring future community care programs are structured to avoid reimbursement methods that pay at "billed charges." The OIG also recommended the under secretary establish controls for future payment systems to prevent overpayments, along with policies to recover overpayments for improperly billed claims. For the Choice program, the Office of Community Care has not completed the previously recommended action plan in the *Audit of the Timeliness and Accuracy*

of Choice Payments Processed through the Fee Basis Claims System. The OIG recommended, as the Office of Community Care continues to rely on the PC3 program, that the office completes the action items listed in the Fee Basis Claims System audit for the PC3 program. The Office of Community Care should take action to close out the recommendations made in the report.

Management Comments and OIG Response

The executive in charge for the Office of the Under Secretary for Health concurred or concurred in principle with all eight of the OIG's recommendations. VHA plans to address many of the recommendations within its new Community Care Network contracts.

In VHA's corrective action plan for each of the recommendations (1 through 5) in finding 1, the Office of Community Care response includes that they will no longer use usual and customary rate language within its contracts but will evaluate payment methodologies and hierarchies to reduce excessive reimbursement. The success of the corrective actions is dependent on the Office of Community Care creating and implementing payment procedures that avoid the practice of paying "billed charges" for medical services without Medicare or VA Fee Schedule rates.

In VHA's corrective action plan for recommendations 6 through 8 in finding 2, the executive in charge indicated VHA's review identified two examples referenced by the OIG as payment errors that VHA contended were paid appropriately using the third-party administrator's invoice amount. The two examples noted were procedure codes 92015 and 97811.[6] In fact, the OIG followed Medicare rules and used published guidelines consisting of relative value unit schedules to determine reimbursement rates. The OIG maintains that the payment errors were calculated appropriately, based on the terms of the PC3/Choice contract, which required contractors to pursue the best possible pricing under Medicare rules.

Because VHA concurred with all recommendations, the OIG will monitor VHA's progress on implementing all proposed actions until they have been completed.

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[6] Of note, if these codes were removed from the analysis, the result would not be statistically significant as to the monetary impact for finding 2.

Contents

Abbreviations

OIG	Office of Inspector General
PC3	Patient-Centered Community Care
VHA	Veterans Health Administration

Introduction

The VA Office of Inspector General (OIG) conducted this audit to provide continued oversight of the Veterans Choice Program for veterans' care in the community by determining the accuracy of Choice healthcare claims payments processed through the Plexis Claims Manager system.

VA amended its Patient-Centered Community Care (PC3) contracts to implement the Choice Program. Although the Choice program ended on June 6, 2019, the Office of Community Care continues to process PC3 claims under the PC3/Choice contract through the Plexis Claims Manager system and the audit findings provide recommendations for future payment contracts. This is the third report in a series that examines Choice healthcare claims payments. The continued oversight of Community Care claim payments is paramount to prevent unwarranted program spending that would otherwise be available for veterans' medical care.

The Veterans Access, Choice, and Accountability Act of 2014 requires that the VA OIG review the accuracy of payments for health care provided under the legislation.[7] The OIG has issued two prior audit reports on the accuracy of the VA Office of Community Care's payments of Choice claims: (1) *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* in December 2017, and (2) *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts* in September 2018.[8] In the first audit, the OIG estimated payment errors totaling $39 million were made to third-party administrators for Choice claims processed through the Fee Basis Claims System from November 1, 2014, through September 30, 2016. In the second audit, the OIG estimated payment errors totaling $101 million were made to third-party administrators for Choice claims that were paid from March 4, 2016, through March 31, 2017.

Veterans Choice Program History

On August 7, 2014, the Veterans Access, Choice, and Accountability Act of 2014 was enacted to improve veterans' access to medical services by appropriating $10 billion for veterans to receive care from non-VA providers. Eligibility for Choice was based on specific criteria relating to wait times for appointments and distance from the nearest medical facility. Choice funds have been administered by the Veterans Health Administration's (VHA) Office of Community Care. Congress appropriated $19.4 billion for the Choice program. The MISSION Act, signed by the

[7] Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (August 7, 2014).

[8] VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, 15-03036-47, December 21, 2017; VA OIG, *Audit of Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, 17-02713-231, September 6, 2018.

President on June 6, 2018, required that the Choice program end on June 6, 2019.[9] On December 20, 2018, the deputy under secretary for health for operations and management issued a memorandum to Veterans Integrated Service Network directors, titled "Community Care Purchasing Authorities." According to the memorandum, "utilization of PC3 [Patient-Centered Community Care] is the preferred routing for referrals until the Community Care Network contract is implemented."

The PC3 contract was set to expire on September 30, 2020, but was extended for an additional six months to March 31, 2021. The Office of Community Care is implementing a new healthcare delivery program nationwide through VA's new Community Care Network.[10]

Table 1 provides dates and amounts of Choice appropriations since the program's inception.

Table 1. Choice Program Appropriations

Law	Date signed	Appropriation amount
Public Law 113-146	August 7, 2014	$10.0 billion
Public Law 115-46	August 12, 2017	$2.1 billion
Public Law 115-96	December 22, 2017	$2.1 billion
Public Law 115-182	June 6, 2018	$5.2 billion
Total		**$19.4 billion**

Source: govinfo.gov on April 14, 2020.

Choice Third-Party Administrator Contract Expenditures

As of February 29, 2020, VA had obligated approximately $9.4 billion of the $19.4 billion and expended about $9.4 billion for Choice program payments to third-party administrators Health Net Federal Services, LLC and TriWest Healthcare Alliance Corporation.[11] Of the $9.4 billion expended, approximately 17 percent was for administrative expenses and the remaining

[9] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182 (June 6, 2018). The MISSION Act consolidated VA's many community care programs in a new Veterans Community Care Program.

[10] As required in the MISSION Act, the Community Care Network is being implemented through new contracts with third-party administrators across six regions. VA awarded the first Community Care Network contracts for Regions 1 through 3 on December 28, 2018, to Optum Public Sector Solutions, Inc. The Community Care Network contract for Region 4 was awarded to TriWest Healthcare Alliance Corp. on August 6, 2019. The contract awards for Regions 5 and 6 were still pending as of May 11, 2020. The PC3 contract will be used to provide medical services for veterans as the Community Care Network is being implemented.

[11] VA entered into contracts with Health Net and TriWest to provide administrative services for the Choice program, including establishing provider networks, scheduling appointments, receiving medical documentation, and making payments for medical care on behalf of VA.

83 percent was for medical care. Table 2 identifies Choice fund expenditures for medical care and related third-party administrative costs as of February 29, 2020.

Table 2. Health Net and TriWest Medical Care and Administrative Expenditures

Fund	Expended	Percentage
Administrative	$1,604,891,476	17%
Medical Care	$7,769,884,577	83%
Total	**$9,374,776,053**	**100%**

Source: Office of Community Care Finance provided the expended amounts as of February 29, 2020.

Office of Community Care

The Office of Community Care manages VA programs allowing veterans to receive medical care from local non-VA providers. The office supports medical care delivery and services to veterans and their families primarily through three business lines: (1) Business Operations and Administration, (2) Delivery Operations, and (3) Performance Improvement and Reporting. This report focuses primarily on the Delivery Operations group, which provided operational management of the Choice program's payment processes. Within Delivery Operations, the Payment Operations and Management directorate has been responsible for administering the Choice program's payment operations. Figure 1 shows the Office of Community Care leadership and organizational chart covering the principal business lines that were involved in Choice program financial management, payment processing, and program oversight.

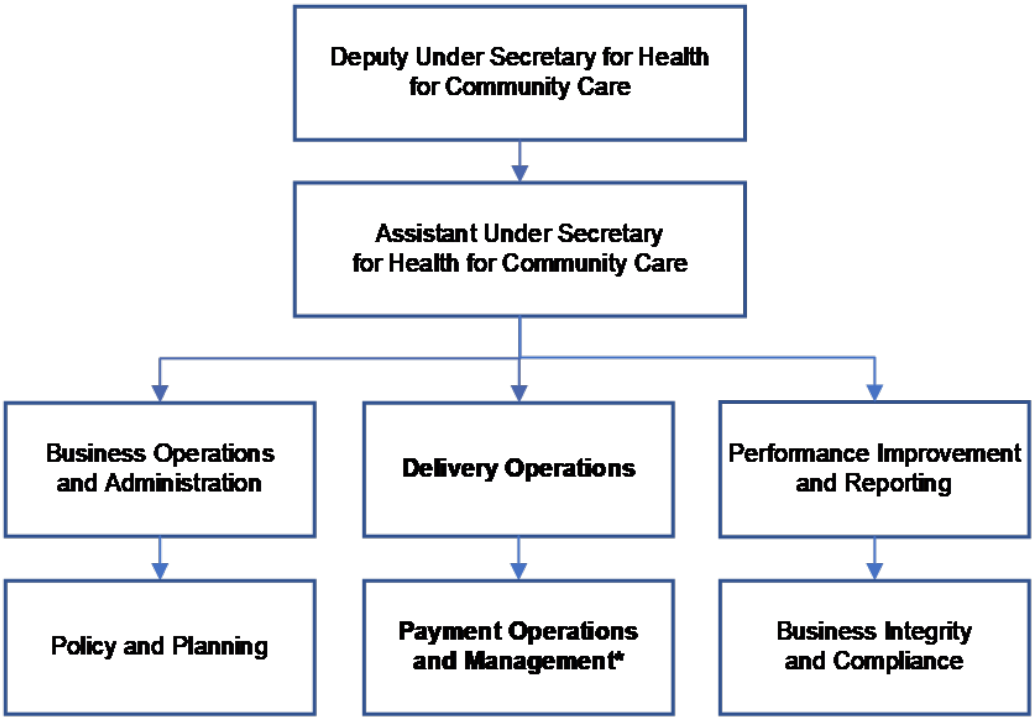

Figure 1. *Office of Community Care leadership and organization chart.*

Source: VHA Office of Community Care Leadership Directory, as of May 2019.

**Formerly known as Claims Adjudication and Reimbursement.*

Choice Contract Reimbursement Methodology

VA's PC3 is a nationwide program for delivering health care in the community and was established on September 3, 2013, following the award of the PC3 contract to both Health Net and TriWest. In October 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the Choice program—referred to as the PC3/Choice contracts.

Under the PC3/Choice contracts, VA makes payments to the third-party administrators rather than care providers. The third-party administrators are responsible for paying providers. VA then reimburses the third-party administrators for payments they make to providers for veterans' medical care obtained through the Choice program. Third-party administrators' billings are submitted to the Office of Community Care electronically, and then processed by the VA Financial Services Center in Austin, Texas. During the period of review for this audit, Choice healthcare claims were processed using Plexis Claims Manager.

The PC3/Choice contract identifies the third-party administrator reimbursement methodology for care delivered by community providers. This methodology follows a specific payment hierarchy consisting first of Medicare fee schedule rates; then, if no Medicare rate is available, the local VA fee schedule should be used, followed by reimbursement at a verifiable usual and customary rate if no Medicare or VA fee schedule rate is available. The payment reimbursement hierarchy is shown in figure 2.

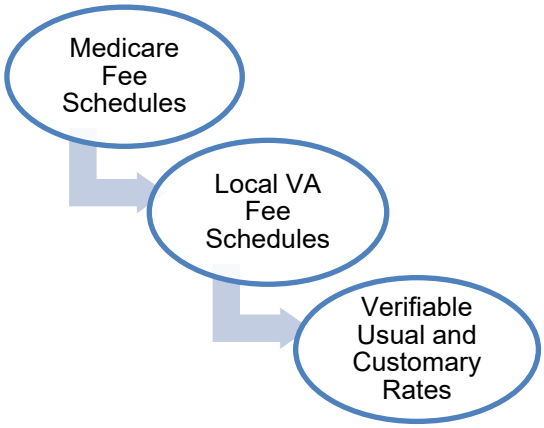

Figure 2. *Choice claims reimbursement payment hierarchy.*

Source: OIG analysis of the PC3/Choice contract.

Choice Program Payment Processes

VA's Fee Basis Claims System. The Office of Community Care processed individual Choice claims via the Fee Basis Claims System from November 2014 through February 2017, according to the OIG report *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*. The Office of Community Care reimbursed third-party administrators at the amount they billed for care provided by community providers, commonly referred to as "billed charges." Therefore, the Office of Community Care did not implement controls to ensure claims were being reimbursed at the appropriate contract reimbursement rates. This payment process ended in February 2017, when the Office of Community Care began using the Plexis Claims Manager system to process payments.

Bulk payment process. The Office of Community Care entered into Choice contract modifications with each third-party administrator to enable the bulk payment of Choice claims beginning in March 2016 and ending in March 2019, according to the OIG report *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Contracts*. The backlog of Choice claims had accumulated with each third-party administrator because of previous contract requirements to submit medical documentation before billing for medical services, processing inefficiencies, and ongoing high claim volumes. Through this payment process, the Office of Community Care reimbursed third-party administrators at "billed charges" and did not adjudicate individual claims received from third-party administrators for the correct contract reimbursement rate. Instead, large groups of invoices were processed and paid in bulk without comparing the charges to the correct contract reimbursement rate.

Plexis Claims Manager. The Plexis Claims Manager system replaced the previous individual claim payment process performed in the Fee Basis Claims System. The VA Financial Services Center processed Choice claims using the Plexis Claims Manager system from February 2017 to June 2019 when the Choice program ended. The first iteration of the Plexis Claims Manager

system was referred to as the Quick Pay process. Under this initial process, the Office of Community Care did not validate claims received from the contractor to verify the claims were priced and reimbursed at the correct contract rate before payments occurred; instead, the Office of Community Care reimbursed claims at "billed charges." The second iteration of the Plexis Claims Manager system, referred to as Choice Claims Adjudication, was implemented in February 2018. This process was developed to adjudicate claims for the correct contract rate before reimbursement. A timeline of these payment processes is shown in figure 3.

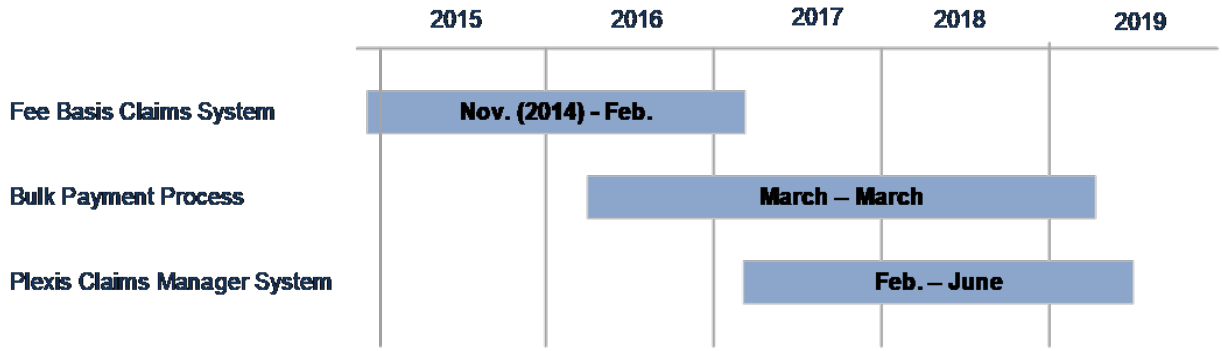

Figure 3. *Timeline of Choice program payment processes.*

Source: OIG analysis of Choice payment process data provided by the Office of Community Care/VA Financial Services Center.

MISSION Act Implementation of the Community Care Network

As previously discussed, the MISSION Act of 2018 required that the Choice program end on June 6, 2019. The Community Care Network was created through a new series of third-party administrator contracts to develop and administer regional networks of licensed healthcare providers. Each regional network contract will serve as the vehicle for VA to purchase care in the community for veterans through one consolidated program that will replace Choice, PC3, and other overlapping community programs. VA awarded the first Community Care Network contracts for Regions 1 through 3 to Optum Public Sector Solutions, Inc. on December 28, 2018. Community Care Network Region 4 was awarded to TriWest on August 6, 2019. Table 3 shows the network implementation schedule as of May 11, 2020.

Table 3. Community Care Network Implementation Schedule

Region	Contractor	Award date	Planned implementation
1	Optum	December 28, 2018	June–December 2019*
2	Optum	December 28, 2018	October 2019–April 2020
3	Optum	December 28, 2018	January–June 2020
4	TriWest	August 6, 2019	June–August 2020
5 and 6	TBD	TBD**	TBD

Source: Provided by Office of Community Care as of May 11, 2020.
**Delivery was effective December 2019.*
***Also, as of May 11, no contracts have been awarded.*

Patient-Centered Community Care Network Bridges Choice and Community Care Networks

According to the Office of Community Care, VA plans to continue to use TriWest's PC3 program until the MISSION Act's new Community Care Network is fully implemented. Effective April 1, 2018, the PC3/Choice contracts were modified to make PC3 contract reimbursement criteria essentially the same as the Choice program. An additional contract modification was effective on October 1, 2018, to transfer all of Health Net's PC3/Choice Regions to TriWest, making TriWest the third-party administrator for the entire PC3 program nationwide.[12] In March 2020, the Office of Community Care extended the PC3 contract with TriWest through March 31, 2021.

[12] On September 29, 2018, TriWest and VA modified the PC3/Choice contract, which added all Health Net PC3/Choice Regions to TriWest. Another modification signed on April 12, 2019, transitioned all Choice authorizations to the PC3 program.

Results and Recommendations

Finding 1: The Office of Community Care Did Not Enforce the Contract Requirement for Verifiable Usual and Customary Rates to Control Program Costs

The Office of Community Care did not establish payment controls to ensure verifiable usual and customary rates were applied to an estimated 1.1 million of 8.6 million Choice claims (13 percent). These claims were processed from February 21, 2017, through December 31, 2018, in the Plexis Claims Manager system. Usual and customary rates reflect what other payers typically reimburse providers in the same geographic area for the same or similar medical services. The Office of Community Care was contractually required to reimburse third-party administrators at verified usual and customary rates when no Medicare or VA fee schedule rates were available. However, instead of establishing payment controls that included reimbursing verifiable usual and customary rates, the Office of Community Care elected to pay "billed charges" for an estimated 1.1 million Choice claims that did not have Medicare or VA fee schedule rates.[13] The Office of Community Care should implement controls to avoid reimbursement methods that pay at "billed charges."

The OIG estimated that the Office of Community Care could have saved approximately $132.1 million if its leaders had established clearly defined usual and customary rates and used these rates when making claim payments in the Plexis Claims Manager system. In addition, the OIG estimated that if payment controls had been implemented to ensure that third-party administrators were reimbursed at usual and customary rates since the inception of the Choice program, the Office of Community Care could have saved approximately $620 million of the $7.8 billion dollars reported by the Office of Community Care as expended for Choice medical care to third-party administrators Health Net and TriWest.

According to the Office of Community Care's director of policy and planning, staff interpreted usual and customary to mean "billed charges" since the term had not been defined in the Choice contract language. Accordingly, the Office of Community Care's Payment Operations and Management directorate instructed payment processing staff to reimburse the amount third-party administrators billed for medical services instead of using a verified usual and customary rate for medical services when there were no Medicare or VA fee schedule rates available, as required by the contract. The audit team informed the Payment Operations and Management directorate of the Revenue Operations division's reasonable charges schedule, which is updated annually and

[13] The VA fee schedule amount is determined by analyzing provider billings within specific localities, which ranks all billings (if the facility has had at least eight billings) from non-VA facilities under the corresponding procedure code during the previous fiscal year, with billings ranked from the highest to the lowest. The VA fee schedule amount is the charge falling at the 75th percentile.

fits the definition of usual and customary rates. The Revenue Operations division uses its reasonable charges schedule to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA or non-VA facility to a veteran who is also a beneficiary under the veteran's other health insurance plan. When the audit team asked the program manager of the Payment Operations and Management directorate why the Office of Community Care's reasonable charges schedule was not considered, the program manager stated that the idea was never pursued because the payment and revenue groups operate independently within the Office of Community Care's management structure.

What the OIG Did

This audit included site visits to the Office of Community Care in Denver, Colorado, in February and May 2019 and the VA Financial Services Center in Austin, Texas, in January and May 2019. The audit team reviewed Choice program payments that were made using the Plexis Claims Manager system from February 21, 2017, through December 31, 2018. The team reviewed a sample of 253 outpatient claims from a universe of 8.6 million claims. The audit team also interviewed program officials responsible for the administration of the Choice program. Appendix A provides additional details on the OIG's audit work.

The Office of Community Care Did Not Establish Contractually Required Verifiable Usual and Customary Rates

As discussed earlier, Office of Community Care leaders did not define usual and customary rates in the Choice contract and then did not establish payment controls for claims without a Medicare or VA fee schedule rate. Instead, Office of Community Care leaders informed their payment staff to reimburse third-party administrators using "billed charges." The Choice contract requires the following for care that falls outside of Medicare:

> Non-Fee Schedule Medical and Surgical Services. 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, and is not included in the regions' VA Fee Schedule, VA will reimburse the Contractor for payment of its provider claims with no profit added as long as the service is part of an authorized episode of care and falls within verifiable usual and customary charges that are billed to payers other than VA. Contractors shall make efforts to obtain the best possible pricing for VA.

According to the VA Financial Services Center managers, the Payment Operations and Management directorate instructed them to reimburse third-party administrators at "billed charges" and not at verified usual and customary rates as required by the contract. This practice resulted in VA reimbursing claims at rates above what would be typically reimbursed to care

providers in the same geographic area for the same or similar medical services. Table 4 shows the OIG's estimate of the number of claims paid at a higher rate than the identified usual and customary rates.[14]

Table 4. Estimated Number of Claims Paid in Excess of Usual and Customary Rates

Third-party administrator	Plexis Claims Manager claims paid	Claims paid in excess of usual and customary rates	Percentage
Health Net	2,469,961	178,094	7%
TriWest	6,163,228	909,692	15%
Total claims*	**8,633,189**	**1,087,786**	**13%**

Source: VA OIG statistical projections based on a sampled universe of paid outpatient Choice claims obtained from February 21, 2017, through December 31, 2018.

**Note: Percentages are rounded.*

The audit team questioned several senior Office of Community Care officials about the Choice contract's definition of usual and customary rates, but officials were unable to explain why the term had not been specifically defined in the contract. They also could not provide any evidence demonstrating that the contract language "verifiable Usual and Customary rates" had been reviewed by the VA Office of General Counsel or underwent any other legal review. According to the Office of Community Care's director of policy and planning, its officials interpreted usual and customary rates to mean "billed charges" since the term had not been defined in the Choice contract language. The director believed that VA's Office of General Counsel had reviewed the Office of Community Care's contract interpretation. However, the director could not provide the audit team with any documentation demonstrating that the Office of Community Care's interpretation had received a legal review. In addition, neither the Procurement Law Group nor the Health Care Law Group within VA's Office of General Counsel could find any communications indicating a review of this contract language.

The director also stated that Office of Community Care officials never considered using the Revenue Operations division's reasonable charges schedule, the rate schedule VA uses to bill third-party insurance for VA services.

The program management officer for the Office of Community Care's Payment Operations and Management division was also not aware that the reasonable charges schedule definition closely

[14] The audit team calculated cost savings primarily using the Office of Community Care's reasonable charges schedule, which is the rate schedule VA uses to bill third-party insurance for VA services. Additional rates were obtained from Optum's EncoderPro.com and DrugReimbursement.com.

aligned with the usual and customary term description within the PC3/Choice contract.[15] Instead, the Payment Operations and Management officials instructed payment processers to use "billed charges" as verified usual and customary rates.

The Office of Community Care's failure to establish a basis for usual and customary rates and implement the contract reimbursement methodology as required significantly contributed to its inability to reduce program costs. As described in the section below, the audit team identified potential costs savings for VA had Office of Community Care officials sought to control their Choice expenditures by using existing rate schedules as a basis for usual and customary rates.

VA Paid More for Choice Medical Services Because Office of Community Care Officials Did Not Define Contract Language

The OIG estimated that the Office of Community Care paid an additional $132.1 million to the third-party administrators by reimbursing "billed charges" on Choice claims instead of defining usual and customary rates and instructing payment staff to limit reimbursements to the rates as specified in the contract. The OIG estimated $132.1 million in cost savings by using the Office of Community Care's reasonable charges, which are based on amounts that third parties reimburse for the same or similar services furnished by private-sector healthcare providers in the same geographic area. The OIG was able to identify these reasonable charges because the Office of Community Care publishes its reasonable charges annually in the Federal Register to inform the public of the amount VA will pay for certain types of medical treatment. For claims containing physician-administered drugs, the audit team applied average wholesale pricing for its basis to determine potential cost savings to VA. The average wholesale price is the suggested list price for sales of a drug by a wholesaler to a pharmacy or other provider and commonly used for pharmaceutical payments.

Table 5 summarizes the estimated monetary effect of reimbursing "billed charges" for Choice claims instead of using verified usual and customary rates.

[15] Healthcare.gov defines usual, customary, and reasonable charges as the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical services. Additionally, VA is authorized to recover or collect reasonable charges from a third party liable under a health-plan contract but may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area under 38 U.S.C. § 1729.

Table 5. Estimated Dollars Paid in Excess of Usual and Customary Rates

Third-party administrator	Plexis Claims Manager payments (in dollars)	Amount overpaid (in dollars)	Percentage
Health Net	425,684,316	27,308,365	6%
TriWest	1,229,560,621	104,786,395	9%
Total dollars*	**1,655,244,937**	**132,094,759**	**8%**

Source: VA OIG statistical projections of overpayment based on a sampled universe of paid outpatient Choice claims obtained from February 21, 2017, through December 31, 2018.
Note: Due to rounding, amount overpaid does not sum up to exact total. Also, percentages are rounded.

In examples 1 and 2, the Office of Community Care could have paid claims at lower rates.

Example 1

TriWest billed, and the Office of Community Care paid, $76,358 for a healthcare procedure. The audit team identified a usual and customary rate for this procedure based on the average wholesale price of $48,564. The Office of Community Care missed an opportunity to save $27,794 by not defining average wholesale prices as the basis for usual and customary rates for drug reimbursements under the PC3/Choice contract.

Example 2

TriWest billed, and the Office of Community Care paid, $60,000 for a healthcare procedure. The audit team identified a usual and customary rate for this procedure based on the VA reasonable rate schedule of $3,227. The Office of Community Care missed an opportunity to save $56,773 by not defining reasonable charges as the basis for usual and customary rates for medical services under the PC3/Choice contract.

Community Care Reimbursements Remain at Risk under the New Community Care Network Contract

The audit team anticipates that VA will remain at risk for overpayments if the practice of reimbursing community care claims at "billed charges" continues. Future community care programs need to ensure they have established reimbursement methodologies for claims that do not have a Medicare or VA fee schedule rate to limit overpayments that would result from reimbursing third-party administrators at "billed charges."

The Office of Community Care needs to ensure it establishes specific limitations to prevent claims from being reimbursed at "billed charges." To lessen this risk, VA will need to specify a reimbursement methodology, such as established usual and customary rates, for claims that do not have a Medicare or VA fee schedule rate. The Office of Community Care will then need to communicate this methodology to the contractors responsible for reimbursing Community Care Network providers to reduce the likelihood of overpayments.

Finding 1 Conclusion

The Office of Community Care could have significantly reduced program costs by properly defining and establishing usual and customary rates to guide and control the payment of claims when there were no Medicare or VA fee schedule rates available. The Office of Community Care did not verify usual and customary rates and then did not incorporate effective controls as required by the contract. Instead, Office of Community Care officials interpreted usual and customary rates to mean "billed charges" and instructed payment staff to reimburse third-party administrators accordingly.

The Office of Community Care needs to clearly define usual and customary rates to ensure charges reimbursed by VA are on par with what providers bill the public for the same services. To do otherwise puts the PC3 and new Community Care Network contracts at risk of incurring unwarranted program costs.

Recommendations 1–5

The OIG recommended the VA deputy under secretary for health for the Office of Community Care take the following actions:

1. Define the terms "verifiable usual and customary charges that are billed to payers other than VA" for the PC3/Choice contract claims.
2. Ensure future community care programs have applicable definitions and guidance for claims without a Medicare or VA fee schedule rate to avoid reimbursements that pay at "billed charges."
3. Create a master usual and customary rate schedule to be used for reimbursement of community care claims without a Medicare or VA fee schedule rate to control program costs.
4. Provide parties responsible for reimbursing PC3/Choice and future community care program claims with usual and customary rate price schedules and a formal written policy on the proper application of those rates.
5. Establish controls for verifiable usual and customary rate payment methodology and establish a payment review process to ensure usual and customary rates are properly applied to the PC3/Choice and future community care program payments.

Management Comments

The executive in charge for the Office of the Under Secretary for Health concurred or concurred in principle with all five recommendations. VHA plans to address many of the recommendations the OIG identified within its new Community Care Network contracts.

For recommendation 1, the executive in charge stated because the PC3/Choice contract will sunset on October 1, 2020, they will not attempt a contract modification. However, VHA agrees "it is necessary to clearly define reimbursement methodologies and terminology in contracts." The Office of Community Care will coordinate with the Office of General Counsel and contracting to clearly define those reimbursement terms and methodologies. For recommendation 2, the Office of Community Care will develop maximum allowable rate reimbursement methodologies and payment hierarchies that avoid excessive reimbursement when Medicare rates are not available.

For recommendation 3, the Office of Community Care will "develop a robust fee schedule that will include more services with maximum allowable rates or other price controls, resulting in fewer healthcare services that default to "billed charges." For recommendation 4, the Office of Community Care will also "develop an updated payment methodology and written guidance on the proper use of the reimbursement rate methodologies and hierarchies." The Office of Community Care plans to develop maximum allowable rate structures consistent with other federal healthcare programs and industry standards as an alternative to creating a usual and customary rate schedule so that reimbursements align with strategies to minimize paying "billed charges."

For recommendation 5, the executive in charge stated VHA will stop using usual and customary rate language within contracts, and the Office of Community Care is evaluating payment methodologies and hierarchies to reduce excessive reimbursement and is committed to reimbursing providers with transparent methodologies. VHA also concurred with the need for oversight and controls and provided information on those in use.

OIG Response

The executive in charge for the Office of the Under Secretary for Health concurred or concurred in principle with each of the 5 recommendations. The Office of Community Care will no longer use usual and customary rate language within its contracts but will evaluate payment methodologies and hierarchies to reduce excessive reimbursement. This action is acceptable if the Office of Community Care creates and implements policy that includes reimbursement methodologies that avoid the payment of "billed charges" for medical services without Medicare or VA Fee schedule rates. In addition, the OIG's intent for recommendations 1 through 5 was not only to ensure the Office of Community Care develops and implements reimbursement methodologies for future contracts, such as the Community Care Network contracts, but also to

make certain that VHA provides clarification regarding the PC3/Choice contract's reimbursement hierarchy/methodology to limit further overpayments.

The OIG will monitor VHA's progress and follow up on the implementation of all recommendations until all proposed actions have been completed, including clarification regarding the PC3/Choice contract's reimbursement hierarchy/methodology. See appendix E for the full text of VHA's comments.

Finding 2: The Office of Community Care Had Not Fully Implemented Several Prior OIG Recommendations and Continued to Make Payment Errors

Based on its sample, the OIG estimated that the Office of Community Care made payment-rate errors on approximately 800,000 of 8.6 million outpatient Choice claims (approximately 10 percent) processed through the Plexis Claims Manager system from February 21, 2017, through December 31, 2018. The OIG estimated approximately $72.4 million in payment-rate errors occurred when the payments did not have the appropriate Medicare or contract-adjusted rate. In addition, the OIG also identified approximately $586,000 in pass-through payment errors during the same period. Pass-through payment errors occurred when third-party administrators billed, and VA reimbursed, more than the third-party administrators paid the providers. As a result of both types of errors, the Office of Community Care made about $73 million in erroneous payments to the Choice third-party administrators for medical services provided under the program. Additional information on the OIG's sampling methodology and calculation of monetary benefits is available in appendixes C and D.

These payment errors occurred, in part, because the Office of Community Care had not fully implemented recommendations made in the VA OIG's December 2017 report regarding payments processed through the Fee Basis Claims System.[16] The Office of Community Care had not designed effective payment and internal control processes for the Choice program that would have prevented payment of improper claims submitted by the third-party administrators.

What the OIG Did

The OIG used a contractor that specializes in processing medical claim payments to review each claim in the audit sample for Medicare pricing accuracy. The audit team identified payment-rate errors from the two payment processes for the Choice Plexis Claims Manager system (Quick Pay and Choice Claims Adjudication). In addition to examining payment-rate errors, the audit team also reviewed each sample claim to identify pass-through payment errors.

Plexis Claims Manager System Payment-Rate Errors

Table 6 shows the estimate of Choice claim payment-rate errors made by the third-party administrators Health Net and TriWest using Plexis Claims Manager's Quick Pay and Choice Claims Adjudication payment processes.

[16] VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, 15-03036-47, December 21, 2017.

Table 6. Estimate of Plexis Claims Manager Payment-Rate Errors

Third-party administrator	Payment-rate errors	Plexis Claims Manager claims	Error rate
Health Net			
Quick Pay	223,773	1,249,400	17.9%
Choice Claims Adjudication	132,415	1,324,145	10.0%
Subtotal	**356,188**	**2,573,545**	**13.8%**
TriWest			
Quick Pay	233,996	2,846,956	8.2%
Choice Claims Adjudication	242,467	3,212,688	7.6%
Subtotal	**476,463**	**6,059,644**	**7.9%**
Total Errors*	**832,651**	**8,633,189**	**9.6%**

Source: VA OIG payment error projections based on a sampled universe of paid outpatient Choice claims obtained from February 21, 2017, through December 31, 2018.

*Note: Percentages are rounded.

Quick Pay Payment Process Errors

The VA Financial Services Center processed Choice claims using Plexis Claims Manager's Quick Pay payment process from February 21, 2017, to February 7, 2018, for TriWest and April 21, 2017, to February 8, 2018, for Health Net. During the Quick Pay process, Office of Community Care staff did not adjudicate Choice claims for correct contract pricing and did not have procedures before payment to prevent overpayments when "billed charges" were more than reimbursement rates allowed by contract. This payment practice has been identified as a significant financial control weakness by two previous OIG audit reports.[17] The audit team used a contractor that specializes in processing medical claim payments to review each claim in the audit sample for Medicare pricing accuracy. Example 3 describes a payment-rate error that occurred during the Plexis Claims Manager system's Quick Pay process.

Example 3

Health Net billed, and the Office of Community Care paid, $80,921 for a medical procedure provided through the Choice program. Under Medicare payment rules,

[17] VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, 15-03036-47, December 21, 2017; VA OIG, *Audit of Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, 17-02713-231, September 6, 2018.

VA should have paid $22,234 for this claim. The Office of Community Care overpaid Health Net by $58,687 for this service by not adjudicating the claim and instead accepting the contractor's billed amount as accurate.

Choice Claims Adjudication Payment Process Errors

The second iteration of the Plexis Claims Manager payment process, referred to as Choice Claims Adjudication, was implemented on February 8, 2018, for TriWest and February 9, 2018, for Health Net, and was ongoing as of June 2020.[18] The OIG's audit period of review for Choice Claims Adjudication claims covered payments made from February 8, 2018, to December 31, 2018. The Choice Claims Adjudication process was developed and implemented to review a claim and determine the correct contract payment rate using a defined reimbursement methodology. This includes comparing the claim with the correct Medicare price, and if no Medicare pricing exists, then applying available VA fee schedule rates.

By adding adjudication of Choice claims for the correct contract rate before reimbursing the claim, the Office of Community Care was able to reduce payment errors by approximately 9 percent. However, the audit team found that payment errors continued in Choice Claims Adjudication even after the Office of Community Care began to adjudicate claims for the correct contract rate. The audit team concluded these errors were caused by missing or outdated Medicare price schedules within the Plexis Claims Manager payment system. Example 4 shows a payment-rate error that occurred during the Plexis Claims Manager Choice Claims Adjudication payment process due to missing information.

Example 4

TriWest billed, and the Office of Community Care paid, $43,605 for a medical procedure provided through the Choice program. Under Medicare payment rules, VA should have paid $21,383 for this claim. The Office of Community Care overpaid TriWest by $22,222 for this service by reimbursing for "billed charges" because the Plexis Claims Manager payment system did not contain the Medicare rate for the specific procedure.

Pass-Through Payment Errors

The PC3/Choice contract required that third-party administrators pass-through the full rate due to the community provider for care administered through the Choice program up to 100 percent of Medicare. The audit team considered a pass-through error to be when the Office of Community

[18] On September 29, 2018, TriWest and VA modified the PC3/Choice contract, which added all Health Net PC3/Choice Regions to TriWest. A contract modification signed on April 12, 2019, transitioned all Choice authorizations to the PC3 program. The Plexis Claims Manager system continues to process PC3 claims. The PC3 program is extended through March 31, 2021.

Care reimbursed the third-party administrator more than the third-party administrator paid the care provider. To identify pass-through payment errors, the audit team collected copies of the remittance advice (documented reimbursement amount) for each of the claims in the sample of 500 claims from the third-party administrators to determine how much the provider was paid.[19] The audit team then compared the amounts third-party administrators paid their providers to the amounts the Office of Community Care paid the third-party administrators. Payment errors were flagged when the third-party administrators paid the providers less than they billed VA for the treatment.

The OIG previously recommended in its *Audit of the Timeliness and Accuracy of Choice Payments Processed Through Fee Basis Claims System* report, released December 21, 2017, that the VHA executive in charge ensure payment processing staff have access to documentation from third-party administrators verifying amounts paid to providers. Access to documentation should ensure the third-party administrators are not billing VA more than they paid the provider for medical claims. In that report, the OIG identified approximately $1.8 million in pass-through overpayments to Health Net.

The OIG identified three pass-through errors resulting in about $586,000 in overpayments to Health Net during this audit. The audit team did not identify any pass-through payment errors in its sample review for TriWest. The pass-through payment errors continued because the Office of Community Care staff still did not have access to third-party administrators' documentation of payments made to care providers for services billed to the Office of Community Care. Third-party administrators have not been contractually required to provide payment documentation. As a result, the Office of Community Care staff were unable to verify that payments made to the provider were for the same amount as the third-party administrator billing.

Example 5 shows a pass-through payment error for which the Office of Community Care paid Health Net more than what Health Net paid its service provider.

Example 5

Health Net billed the Office of Community Care $503,892 for outpatient medical services provided through the Choice program for treatment provided on April 25, 2017. The audit team reviewed the provider's remittance advice and determined Health Net paid the provider $3,290 for this service but did not pass the rate through to the Office of Community Care. Health Net has not been contractually required to provide remittance advice with its claims, preventing the Office of Community Care from having the necessary information to correctly

[19] "Remittance advice" documents how much the third-party administrator reimbursed the network provider for the medical service. The team reviewed a statistical sample of 500 claims, consisting of 253 outpatient and 247 inpatient claims paid between February 21, 2017, and December 31, 2018.

pay this claim. As a result, the Office of Community Care overpaid the claim by $500,602.

Financial Effect of Payment Errors

The OIG estimated that the Office of Community Care made approximately $73 million in payment errors for Choice claims paid from February 21, 2017, through December 31, 2018. Table 7 shows the estimated amount of these errors by third-party administrator and payment methodology.

Table 7. Estimated Monetary Impact of the Plexis Claims Manager System's Claim Payment Errors

Third-party administrator	Payment-rate errors (in dollars)	Pass-through errors (in dollars)	Total (in dollars)
Health Net			
Quick Pay	16,795,083	500,602	17,295,685
Choice Claims Adjudication	14,005,638	85,011	14,090,649
Subtotal	**30,800,721**	**585,613**	**31,386,334**
TriWest			
Quick Pay	20,330,962	0	20,330,962
Choice Claims Adjudication	21,304,802	0	21,304,802
Subtotal	**41,635,764**	**0**	**41,635,764**
Total dollars*	**72,436,485**	**585,613***	**73,022,098**

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice claims paid via the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

**Pass-through error totals reflect actual errors and not projected estimates. The OIG identified three errors from its sample review of 500 claims.*

The Office of Community Care Did Not Address Several Prior OIG Audit Recommendations

As the OIG described in its December 2017 Fee Basis Claims System audit report, payment-rate and pass-through payment errors occurred because the Office of Community Care did not design effective payment and internal control processes for the PC3/Choice contract that would prevent payment of improper claims submitted by third-party administrators.

The OIG has again determined that the Office of Community Care did not ensure there were complete payment-rate schedules or guidance to appropriately enforce Choice contract payment methodology and prevent program overpayments. This would occur through sufficient oversight, which should include formal written guidance provided to the VA Financial Services Center or comprehensive audits performed by the Office of Community Care that would be independent of the VA Financial Services Center's internal review of its own work.[20]

The Office of Community Care's director of business integrity and compliance stated that the office had chosen not to develop standard operating procedures for third-party administrators or the VA Financial Services Center's claims processing staff for the Choice program. The Office of Community Care is the responsible party for ensuring payments are paid accurately; however, it deferred much of its oversight of those payments to the VA Financial Services Center, which was adjudicating the claims on behalf of the Office of Community Care.

Next, only one payment audit, with a narrow scope, was performed by the Office of Community Care over Choice payments made through the Plexis Claims Manager, while the VA Financial Services Center performed verification of all payments made in the Plexis Claims Manager Quick Pay payment process.

As a result of the VA Financial Services Center post-payment review, they determined that VA overpaid $69.9 million; this included overpayments to TriWest for approximately $50.5 million and Health Net for approximately $19.4 million when the Quick Pay process was used. In spite of these findings by the VA Financial Services Center and the previous OIG audit findings identifying that the process of reimbursing "billed charges" has led to overpayments, the Office of Community Care did not implement a prepayment review to ensure amounts reimbursed were consistent with contracted reimbursement methodology or contracted rates before reimbursing third-party administrators under the Community Care Network payment process.

As a result, payment errors will continue until formal policies are created, prepayment controls are implemented, and the Office of Community Care takes an active oversight role to ensure payments are processed in a consistent and accurate manner.

In the OIG's 2017 Fee Basis Claims System report, recommendation 1 stated,

> We recommended the Executive in Charge, Veterans Health Administration, develop and issue written payment policies to guide staff processing medical claims received from [third-party administrators] as well as establish expectations and obligations for the [third-party administrators] that submit invoices for payment.

[20] As described below, the recommendation has remained open due to the lack of a fully executed and documented implementation plan.

The Office of Community Care responded with the following proposed action plan:

> VHA will provide the following documentation at completion of this action:
>
> - [Plexis Claims Manager] Choice User Manual [Financial Services Center] (employee processes for Choice)
> - Contractor Claims Processing [Standard Operating Procedures] (outlines contractor facing processes)
> - [Office of Community Care] Claims Processing [Standard Operating Procedures] (outlines VA processes)

VA concurred with the recommendation and stated the following:

> VHA agrees that clear policies and procedures are necessary for claims processors and third-party administrators… VHA looks toward the award of its future Community Care Network (CCN) contracts which constitute the future state of payment and claims processing to third-Party Administrators (TPA). VA anticipates awarding the first region-based contract by the end of calendar year 2017, with the remaining regions to be awards [*sic*] throughout calendar year 2018. A Contractor Claims Processing Standard Operating Procedure (SOP) and VHA Office of Community Care (OCC) Claims Processing SOP are being developed to clearly outline procedures and expectations for VA employees and TPAs.

The OIG has been unable to close this recommendation because the Office of Community Care has not developed or provided detailed payment guidance to third-party administrators for processing Choice claim payments. The action plan provided steps to address the recommendation in the Community Care Network with the assumption that it would soon replace Choice; however, it has taken years longer to fully implement the network. This has meant that VA has relied on PC3 and Choice to fill that gap. In the PC3 and Choice programs, the Office of Community Care have not completed the action plan for the Fee Basis Claims System audit recommendations. The OIG recommends that, as VA continues to rely on PC3, VA completes the action items that it listed in the Fee Basis Claims System audit for the PC3 program.

Community Care Network Contract Reimbursements Remain at Risk for Overpayment without Prepayment Controls

In previous audits of Choice payments, when VA used payment systems or methodologies that did not adjudicate claims before reimbursing third-party administrators, and instead reimbursed at "billed charges," the OIG determined that overpayments were due to VA not reviewing claims

for the correct contract rate before reimbursing the third-party administrators.[21] The audit team anticipates that VA will remain at risk for more overpayments under the Community Care Network contracts.

Under these new contracts, the Office of Community Care will again return to paying third-party administrators at "billed charges" without a prepayment review for the correct contract rate and will rely on post-payment audits performed by a contractor selected by the third-party administrators to enforce contract rate reimbursement accuracy.[22]

Using post-payment audits to recover overpayments delays the availability of community care resources and incurs the additional cost of hiring a contractor to manage the identification of overpayments. In addition, VA will have difficulty collecting overpayments in situations where payment rules have not been clearly defined by Office of Community Care policy and Community Care contract language.

Finding 2 Conclusion

Without full and effective implementation of the OIG's prior audit recommendations, future payments made under the PC3/Choice contract with TriWest will continue to be at risk for overpayment. According to the VA Financial Services Center, the Plexis Claims Manager system will continue to process PC3 payments as the Community Care Network is implemented. Overpayments reduce the amount of funding available to authorize additional care in the community for veterans who are waiting for medical treatment.

Recommendations 6–8

The OIG recommended the VA deputy under secretary for health for the Office of Community Care take the following actions:

6. Ensure payment-rate schedules used by the Plexis Claims Manager and future payment systems to support the PC3/Choice and future community care contracts are current, accurate, and complete to prevent overpayments.
7. Ensure that the Office of Community Care determines an appropriate reimbursement process for the identified pass-through errors in this report.

[21] VA OIG, *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, and VA OIG, *Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts.*

[22] According to the Community Care Network contracts, third-party administrators will hire independent auditors. VA will approve the auditing plan before the audit. The auditors' findings will be used by VA to determine incentives or disincentives for payment accuracy.

8. Ensure the Office of Community Care establishes formal policies and procedures to identify and recover overpayments from PC3/Choice third-party administrators for improperly billed claims.

For the Choice programs, the Office of Community Care also has not completed the action plan for the *Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System* (previous audit recommendations listed below). The OIG recommends, as the Office of Community Care continues to rely on the PC3 program, that the office complete the action items listed in the Fee Basis Claims System audit for the PC3 program. The Office of Community Care should take action to close out these recommendations made in the VA OIG report:

- The executive in charge, Veterans Health Administration, develops and issues written payment policies to guide staff processing medical claims received from third-party administrators, as well as establishes expectations and obligations for the third-party administrators that submit invoices for payment.
- The executive in charge, Veterans Health Administration, ensures payment processing staff have access to documentation from the third-party administrators verifying amounts paid to providers to ensure the third-party administrators are not billing VA more than they paid the provider for medical claims.
- The executive in charge, Veterans Health Administration, ensures VA performs post-payment audits on a periodic basis to determine if payments made to third-party administrators for medical care are accurate.

Management Comments

The executive in charge for the Office of the Under Secretary for Health concurred or concurred in principle with recommendations 6 through 8. VHA plans to address many of the recommendations the OIG identified within its new Community Care Network contracts.

For recommendation 6, the executive in charge concurred in principle and stated, "With the implementation of the recovery audit contract, current Financial Services Center post audits, and enforcement of strict standards within new contracts (Community Care Network), VA has established controls to prevent overpayments, while putting mechanisms into place to recapture overpayments. The Office of Community Care will develop an updated payment methodology and written guidance on the proper use of the reimbursement rate methodologies and hierarchies."

However, the executive in charge also commented that VHA had insufficient information on the OIG sample of 253 claims used for its analysis or the specific details on its cost-saving calculations. Specifically, he stated that the OIG's examples of errors with procedure codes 92015 and 97811 were paid appropriately using the third-party administrator's invoiced amounts because these medical services did not have a Medicare rate at the time services were rendered. VHA questioned the dollar amounts of the overpayments, errors and cost-saving opportunities referenced throughout the OIG report and believes the value of overpayments is significantly less than reported in this audit.

For recommendation 7, VHA's comments indicated one of the payment errors has been refunded and the other two will be included in the Health Net PC3 contract close-out reconciliation.

For recommendation 8, the executive in charge noted that significant improvements have been made implementing prior OIG recommendations. He stated the "Office of Community Care will continue to improve processes and internal controls to ensure payments made to Third-Party Administrators (TPA) and community providers demonstrate quality and cost effectiveness to ensure good financial stewardship." Moreover, VHA will "recover overpayments from the third-party administrator after the audit data is validated and overpayments are confirmed."

OIG Response

The executive in charge for the Office of the Under Secretary for Health concurred or concurred in principle and provided an action plan for each of the three recommendations from finding 2. The OIG offers the following response to VHA's comments regarding recommendation 6.

On August 12, 2020, the OIG provided VHA's Office of Community Care leaders with specific information on the results of the audit sample analysis including a list of the 253 outpatient claims sampled with line-item details for all 32 payment errors. VHA did not request any additional information after this data was provided. The OIG statistically projected from the 32 payment errors identified in this report a total overpayment estimate of $72.4 million. The

result is a statistical estimate that is not limited to the sample selected but instead estimates the probability of overpayments across the entire population covered in this report.

The executive in charge indicated VHA's review identified two examples referenced by the OIG as payment errors that VHA contended were paid appropriately using the TPA's invoice amount. The two examples noted were procedure codes 92015 and 97811.[23] The OIG followed Medicare rules and used published guidelines consisting of relative value unit schedules to determine reimbursement rates. The OIG maintains that the payment errors were calculated appropriately, based on the terms of the PC3/Choice contract which required contractors to pursue the best possible pricing under Medicare rules. Medicare rules include methodologies for calculating payments for services using relative value unit schedules. The Office of Community Care had initially used relative value unit schedules to limit reimbursements for claims processed in the Plexis Claims Manager system but stopped applying these Medicare rules at the request of the third-party administrator, TriWest Healthcare Alliance Corporation. The OIG applied these Medicare rules to calculate the best price available to the government, which was lower than the invoiced amounts paid by VHA.

The OIG will monitor VHA's progress and follow up on the implementation of all recommendations until the proposed actions have been completed. This includes establishing formal policies and procedures to guide the identification and recovery of overpayments from PC3/Choice third-party administrators for all claims paid improperly under the PC3/Choice contract. See appendix E for the full text of VHA's comments.

[23] Of note, while the OIG contends its analysis is correct, even if these codes were removed from the analysis, the result would not be statistically significant as to the monetary impact for finding 2.

Appendix A: Background

Entities Involved in Processing Choice Claims

The Office of Community Care provides program direction and oversight for the Choice program. The office represents a single accountable authority for developing administrative processes, policies, regulations, and directives associated with the delivery of VA health benefits programs. It assists the under secretary for health by developing, implementing, and supporting various aspects of administrative healthcare programs such as the PC3 and Choice programs, in addition to other community care programs.

VA Financial Services Center, through a service-level agreement with the Office of Community Care, is contracted to process Choice claims using the Plexis Claims Manager system.

Third-Party Administrators are responsible for establishing networks of non-VA providers to meet the medical needs of eligible veterans. They are also responsible for establishing call centers, scheduling appointments, and coordinating the transmission of medical documents between the Office of Community Care and non-VA providers. These administrators pay providers for service-connected and nonservice-connected care at the rates negotiated in accordance with the Veterans Access, Choice, and Accountability Act of 2014 or PC3. They reimburse community providers before submitting claims to the Office of Community Care for payment.

Choice Program

The Veterans Access, Choice, and Accountability Act of 2014 allowed VA to send veterans to non-VA providers to receive health care when the care was unavailable at the local VA medical facility. The act was signed into law on August 7, 2014 and established the Veterans Choice Program. On October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the Choice program, including establishing provider networks, scheduling appointments, submitting medical documentation received from providers, and making payments for medical care on behalf of VA. Choice was a temporary program that was initially funded with $10 billion and set to expire either when these funds were expended or by August 7, 2017. Subsequent legislation appropriated an additional $9.4 billion for a total of $19.4 billion and extended Choice until June 6, 2019, when the program ended.

Significant Program Changes

Effective April 1, 2018, the PC3/Choice contracts with TriWest were modified to make PC3 essentially the same as Choice by making pass-through language, reimbursement rates, and administrative fees the same for both programs. On September 30, 2018, the PC3/Choice

contract ended with Health Net and discontinued Health Net's participation in both the PC3 and Choice programs.

On October 1, 2018, the PC3/Choice contracts were modified with TriWest to consolidate all Health Net regions to TriWest, making TriWest the sole provider for both PC3 and Choice until the Choice program ended on June 6, 2019. As a result, the VA Financial Services Center started processing PC3 claims in February 2019 as it consolidated PC3 payment processing to a central location. In the past, PC3 claims were paid locally by VA medical centers. This change was in anticipation of PC3 becoming the main vehicle for care in the community as Choice ended and the Community Care Network was implemented.

The MISSION Act of 2018 required that Choice end on June 6, 2019.[24] The act consolidated VA's many community care programs into a new Veterans Community Care Program. With the date approaching, the deputy under secretary for health for operations and management issued a memorandum to Veterans Integrated Service Network directors on December 20, 2018, titled "Community Care Purchasing Authorities." The memorandum stated that PC3 was the preferred routing for referrals until the Community Care Network contracts were fully implemented. The Office of Community Care has processed approximately $4.2 billion in PC3 healthcare claims payments from October 1, 2019 through April 30, 2020.

Future of Community Care

Following the MISSION Act's required sunset date of the Choice program by June 6, 2019, the Community Care Network is being implemented through new contracts with third-party administrators across six regions. VA awarded the first Community Care Network contracts for Regions 1 through 3 on December 28, 2018, to Optum Public Sector Solutions, Inc. VA is moving forward with deployment of the Community Care Network contracts. The Community Care Network contract for Region 4 was awarded to TriWest on August 6, 2019. As of May 11, 2020, the Office of Community Care informed the OIG that the contract award for Region 5 was still pending and there was not enough interest to proceed with a separate procurement for Region 6.

In support of the new program, the Office of Community Care has developed a payment system to process claims called the Community Care Reimbursement System. Unlike the Plexis Claims Manager Choice Claims Adjudication System, the Community Care Reimbursement System will not be adjudicating claims for the correct contract rate. VA deployed the Community Care Reimbursement System with the implementation of the Community Care Network.

[24] On June 6, 2018, the President signed the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, also known as the VA MISSION Act of 2018.

Appendix B: Scope and Methodology

Scope

The audit team performed its audit work from December 2018 to June 2020 to determine the accuracy of payments for Choice healthcare claims processed through the Plexis Claims Manager system. The audit included a universe of approximately 8.6 million outpatient healthcare claims estimated at $1.7 billion processed by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

Methodology

To achieve the objective, the audit team reviewed Choice program contracts, requested Choice provider remittance advice (documented reimbursement amount) for samples from third-party administrators, and interviewed officials from the Office of Community Care and the VA Financial Services Center. The audit team also used a third-party vendor to evaluate medical claims in the audit sample to determine if the Medicare rates applied were correct.

The Choice healthcare claims payment data were from the VA Financial Services Center's Plexis Claims Manager system. The audit team reviewed a statistical sample of 500 paid outpatient and inpatient claims within the payment universe. Inpatient claims were only reviewed for pass-through payment errors. Appendix C contains details of the statistical sampling methodology.

Usual and Customary Rate Review

The Office of Community Care's Revenue Operations division uses reasonable charges to bill third-party insurers for nonservice-connected medical treatment provided by VA. Revenue Operations is required to publish reasonable charges, VA's billing rates for third-party insurers, annually. The audit team calculated cost savings using the Office of Community Care's reasonable charges, national prices from Optum 360 EncoderPro.com as provided by the Financial Services Center, and the average wholesale price for prescription drugs as the basis for usual and customary rates. The Office of Community Care's reasonable charges are "based on amounts that third parties pay for the same services furnished by private-sector health care providers in the same geographic area." The Optum 360 EncoderPro.com is an online medical coding tool used by the VA Financial Services Center to reference national pay rates. The average wholesale price is a common industry benchmark used by government agencies and private payers to negotiate contract discounts.

Payment-Rate Review

To determine payment-rate accuracy, the audit team reviewed each sample claim by comparing the amounts paid for each current procedural terminology code or healthcare common procedure coding system code with Medicare and local VA fee schedules.

Pass-Through Review

To determine pass-through errors, the audit team collected copies of the remittance advice for each of the claims in the samples from third-party administrators to determine what third-party administrators paid the providers and compare it to the amount the Office of Community Care paid.

Fraud Assessment

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

- Performing an assessment to identify fraud indicators and the likelihood of their occurrence; and
- Reviewing provider claim and remittance advice information provided by third-party administrators.

Data Reliability

The OIG Data Analytics Division provided the audit team with Plexis Claims Manager claim data. The audit team performed the data reliability steps detailed in the next paragraph for all the claims from the statistical sample.

For the data reliability test of all Plexis Claims Manager statistically selected sample items, the audit team performed a validation on the unique patient control number for each sample against the remittance advice provided by Health Net and TriWest. The audit team determined the samples matched the patient control numbers of the remittance advice and then did a reconciliation of the payment data for each of the statistical samples against the VA Financial Management System. After reconciliation, the audit team found no payment data errors with the statistical samples. The OIG concluded the data were valid and sufficiently reliable to support the audit's objectives and conclusions.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions

based on audit objectives. The OIG concluded that the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

Approach

To determine the accuracy of Choice healthcare payments made under the Plexis Claims Manager processing system, the audit team sampled paid claims from Health Net and TriWest from February 21, 2017, through December 31, 2018.

Population

The audit team identified 8,633,189 paid outpatient healthcare claims that resulted in $1,655,244,937 of Plexis Claims Manager Choice healthcare payments made from February 21, 2017, through December 31, 2018.

Sampling Design

The audit team's statistical samples consisted of 253 outpatient medical claims from the Plexis Claims Manager payment process system paid from February 21, 2017, through December 31, 2018. The OIG stratified the outpatient healthcare service claims population into four strata based on Quick Pay and Choice Claims Adjudication for both Health Net and TriWest. The following table describes the total Plexis Claims Manager outpatient claim count, total Plexis Claims Manager dollar amount, and sampled items for each third-party administrator.

Table C.1.a. Plexis Claims Manager System (Outpatient Claims)

Stratum	Description	Plexis Claims Manager claims	Plexis Claims Manager dollar amount	Sampled items
1	Health Net (Quick Pay)	1,249,400	$207,751,837	67
2	Health Net (Choice Claims Adjudication)	1,324,145	$222,515,046	60
3	TriWest (Quick Pay)	2,846,956	$590,174,226	73
4	TriWest (Choice Claims Adjudication)	3,212,688	$634,803,828	53
	Total	**8,633,189**	**$1,655,244,937**	**253**

Source: The VA OIG sampled universe of outpatient Choice claims paid by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

In addition, the audit team's statistical samples consisted of 247 inpatient medical claims from the Plexis Claims Manager payment process system paid from February 21, 2017, through December 31, 2018. The inpatient medical claims were only used for the pass-through medical claims review and analysis. The OIG stratified the inpatient healthcare service claims population into four strata based on Quick Pay and Choice Claims Adjudication for both Health Net and TriWest. The following table describes the total Plexis Claims Manager inpatient claim count, total Plexis Claims Manager dollar amount, and sampled items for each third-party administrator.

Table C.1.b. Plexis Claims Manager System (Inpatient Claims)

Stratum	Description	Plexis Claims Manager claims	Plexis Claims Manager dollar amount	Sampled items
1	Health Net (Quick Pay)	127,041	$206,553,003	45
2	Health Net (Choice Claims Adjudication)	180,950	$305,335,315	78
3	TriWest (Quick Pay)	386,912	$610,290,459	50
4	TriWest (Choice Claims Adjudication)	1,045,065	$1,747,881,062	74
	Total	**1,739,968**	**$2,870,059,839**	**247**

Source: The VA OIG sampled universe of inpatient Choice claims paid by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

Weights

The OIG calculated estimates in this report using weighted sample data. Samples were weighted to represent the population from which they were drawn. The OIG team uses the weights to compute estimates. For example, the OIG team calculated the error rate point estimates by summing the sampling weights for all sample records that contained the error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The point estimate (e.g., estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication or Taylor-Series Approximation methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

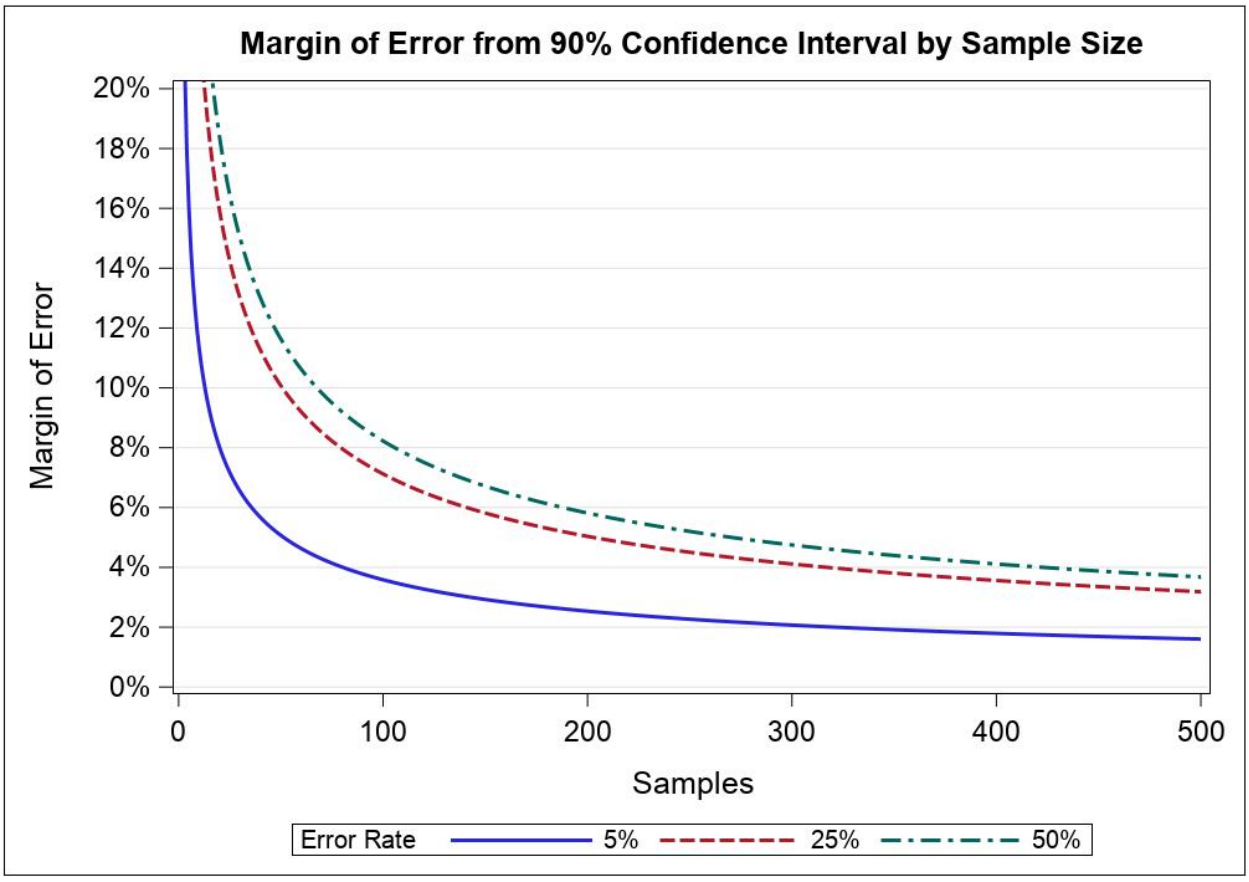

Figure C.1. *Effect of sample size on margin of error.*

Source: Margin of error table from VA OIG statistician.

Projections

Table C.2. Estimated Number of Usual and Customary Rates and Payment-Rate Errors

Third-party administrator	Plexis Claims Manager claims	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Health Net							
Usual and customary rate (Quick Pay & Choice Claims Adjudication)	2,469,961	178,094	95,415	82,679	273,509	9	127
Payment-rate errors (Quick Pay)	1,249,400	223,773	97,358	126,415	321,131	12	67
Payment-rate errors (Choice Claims Adjudication)	1,324,145	132,415	85,384	47,030	217,799	6	60
Payment-rate errors subtotal	**2,573,545**	**356,188**	**129,495**	**226,692**	**485,683**	**18**	**127**
TriWest							
Usual and customary rate (Quick Pay & Choice Claims Adjudication)	6,163,228	909,692	319,182	590,510	1,228,874	20	126
Payment-rate errors (Quick Pay)	2,846,956	233,996	152,143	81,854	386,139	6	73
Payment-rate errors (Choice Claims Adjudication)	3,212,688	242,467	194,297	48,170	436,764	4	53
Payment-rate errors subtotal	**6,059,644**	**476,463**	**246,776**	**229,687**	**723,240**	**10**	**126**
Combined weighted estimate for Health Net and TriWest							

Third-party administrator	Plexis Claims Manager claims	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Combined usual and customary rates	8,633,189	1,087,786	333,138	754,648	1,420,924	29	253
Combined payment-rate errors	8,633,189	832,651	278,689	553,962	1,111,340	28	253

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice claims paid by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

[*] *Appendix tables C.2-C.6 contain projected estimates that were rounded and do not sum.*

Table C.3. Estimated Percentage of Usual and Customary Rates and Payment-Rate Errors

Third-party administrator	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Health Net						
Usual and customary rates (Quick Pay & Choice Claims Adjudication)	6.9%	3.7%	3.2%	10.6%	9	127
Payment-rate errors (Quick Pay & Choice Claims Adjudication)	13.8%	5.0%	8.8%	18.9%	18	127
Payment-rate errors (Quick Pay)	17.9%	7.8%	10.1%	25.7%	12	127
Payment-rate errors (Choice Claims Adjudication)	10.0%	6.5%	3.6%	16.5%	6	127
TriWest						
Usual and customary rates (Quick Pay & Choice Claims Adjudication)	15.0%	5.3%	9.7%	20.3%	20	126
Payment-rate errors (Quick Pay & Choice Claims Adjudication)	7.9%	4.1%	3.8%	11.9%	10	126
Payment-rate errors (Quick Pay)	8.2%	5.3%	2.9%	13.6%	6	126
Payment-rate errors (Choice Claims Adjudication)	7.6%	6.0%	1.5%	13.6%	4	126
Combined weighted estimate for Health Net and TriWest						
Combined usual and customary rates	12.6%	3.9%	8.7%	16.5%	29	253

Third-party administrator	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Combined payment-rate errors	9.6%	3.2%	6.4%	12.9%	28	253

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice claims paid by the Plexis Claims Manager payment from February 21, 2017, through December 31, 2018.

Table C.4. Estimated Dollar Amount of Usual and Customary Rates Errors

Third-party administrator	Plexis Claims Manager payments	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Health Net							
Usual and customary rates (Quick Pay and Choice Claims Adjudication)	$425,684,316	$27,308,365	$15,791,115	$11,517,250	$43,099,480	9	127
TriWest							
Usual and customary rates (Quick Pay and Choice Claims Adjudication)	$1,229,560,621	$104,786,395	$42,181,623	$62,604,772	$146,968,017	19	126
Combined weighted estimate							
Combined usual and customary rates	$1,655,244,937	$132,094,759	$45,040,522	$87,054,238	$177,135,281	28	253

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice claims paid by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

Table C.5. Estimated Dollar Percentage of Usual and Customary Rates Errors

Third-party administrator	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Health Net						
Usual and customary rates (Quick Pay & Choice Claims Adjudication)	6%	4%	3%	10%	9	127
TriWest						
Usual and customary rates (Quick Pay & Choice Claims Adjudication)	9%	3%	5%	12%	19	126
Combined weighted estimate for Health Net and TriWest						
Combined usual and customary rates	8%	3%	5%	11%	28	253

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice claims paid by the Plexis Claims Manager system from February 21, 2017, through December 31, 2018.

Table C.6. Estimated Dollar Amount of Payment-Rate Errors

Third-party administrator	Estimated error	Margin of error	Confidence interval lower limit 90%	Confidence interval upper limit 90%	Sample size	Total sample size
Health Net						
Quick Pay payment-rate errors	$16,795,083	$8,582,345	$8,212,738	$25,377,428	12	67
Choice Claims Adjudication payment-rate errors	$14,005,638	$9,380,176	$4,625,462	$23,385,813	6	60
Payment-rate error subtotal	$30,800,721	$12,713,943	$18,086,778	$43,514,663	18	127
TriWest						
Quick Pay payment-rate errors	$20,330,962	$16,342,314	$3,988,648	$36,673,275	6	73
Choice Claims Adjudication payment-rate errors	$21,304,802	$17,491,162	$3,813,640	$38,795,964	4	53
Payment-rate error subtotal	$41,635,764	$23,937,668	$17,698,096	$65,573,432	10	126
Combined weighted estimate						
Combined payment-rate errors	$72,436,485	$27,104,544	$45,331,941	$99,541,029	28*	253

Source: VA OIG payment error projections based on a sampled universe of outpatient Choice outpatient claims paid by the Plexis Claims Manager payment from February 21, 2017, through December 31, 2018.
**Note: The VA OIG projected 32 line-items that were identified as errors from the sample of 28 claims.*

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
1-5	Define and utilize usual and customary rates as required by the PC3/Contract.	$132.1 million	$0
6-8	Improve the Choice payment processing system to prevent improper payments and recover overpayments. (Questioned costs consist of payments made that did not meet the PC3/Choice program contracts payment criteria. See Note below.)	$0	$73 million
	Total	**$132.1 million**	**$73 million**

Note: The OIG considered the approximately $73 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 statutory, contractual, administrative, or other legally applicable requirements."

Appendix E: Management Comments

Department of Veterans Affairs Memorandum

Date: September 3, 2020

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

Subj: OIG Draft Report, Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager (Project Number 2019-00226-R8-0001) (VIEWS 03170806)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the Office of Inspector General (OIG) draft report titled, Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager. The attachment contains the Veterans Health Administration (VHA)'s action plan to the Office of Inspector General (OIG)'s eight recommendations.
2. VHA's Office of Community Care (OCC) agrees with OIG on the importance of clearly defining reimbursement methodologies and contract terminology. The OIG conducted three reviews of the – Patient Centered Community Care (PC3)/CHOICE program reimbursement process, to include examining payments made through the Fee Basis Claims System (FBCS) as well as the Plexis Claims Manager System. VHA will make changes to future contracts based on this and prior OIG audit findings, but will not expend resources toward revising the current contract that ends 34 days from the writing of this memorandum.
3. VHA is committed to fulfilling its obligation to be a good steward of taxpayers' dollars; ensuring provider reimbursement is fair and accurate. VHA continues to modernize procedures and reviews to ensure rate schedules and hierarchies used in claims processing and payment systems are consistent with industry standards, current, accurate, and complete. As VHA modernizes the VA fee schedule, it will develop additional rate reimbursement methodologies that minimize uncertainty and avoid excessive reimbursement.
4. VHA cannot wholly concur with OIG's findings and dollar figures. VHA was not provided enough information on the claims sample utilized by OIG for analysis or specific details regarding the subsequent cost saving calculations computed by OIG that were based on the 253 claims in the sample. We found some of the examples referenced by OIG as errors in the report (for example procedure codes 92015 and 97811) were paid appropriately using the Third Party Administrator's invoiced amount, as these services did not have Medicare rates at the time services were rendered. Therefore, these defaulted to reimbursing the lesser of the VA Fee
5. Schedule or billed charges. These differences call into question the dollar amounts of overpayments, errors and cost saving opportunities referenced throughout the OIG report. VHA cannot validate the value of overpayments but are confident it is significantly less than reported in this audit.

The OIG removed point of contact information prior to publication.

(Original signed by)
Richard A. Stone, M.D.
Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Office of Inspector General (OIG) Draft Report: Lack of Adequate Controls for Choice Payments Processed through the Plexis Claims Manager System

Date of Draft Report: July 16, 2020

Recommendations/ Actions | Status | Completion Date

Recommendation 1: Define the terms “verifiable usual and customary charges that are billed to payers other than VA” for the PC3/Choice contract claims.

VHA Comment: Concur in Principle

The Patient Centered Community Care (PC3)/Choice contract will sunset on October 1, 2020, making it impractical for VHA to attempt a PC3/Choice contract modification at this time. VHA agrees it is necessary to clearly define reimbursement methodologies and terminology in contracts. The Office of Community Care (OCC) will coordinate with the Office of General Counsel (OGC) and contracting to clearly define reimbursement terms and methodologies. OCC will develop reimbursement language and payment hierarchies to minimize uncertainty and avoid excessive reimbursement.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 2: Ensure future community care programs have applicable definitions and guidance for claims without a Medicare or VA Fee Schedule rate to avoid reimbursement methods that pay at “billed charges”.

VHA Comment: Concur

As VHA continues to modernize the VA fee schedule, the Office of Community Care will develop maximum allowable rate reimbursement methodologies and payment hierarchies that minimize uncertainty and avoid excessive reimbursement when Medicare rates are not available.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 3: Create a master usual and customary rate schedule to be used for reimbursement of community care claims without a Medicare or VA Fee Schedule rate to control program costs.

VHA Comment: Concur in Principle

The Office of Community Care (OCC) is developing a robust fee schedule that will include more services with maximum allowable rates or other price controls, resulting in fewer healthcare services that default to billed charges. OCC is evaluating reimbursement methodologies and hierarchies from other Federal and commercial health plans to reduce excessive reimbursement. There are wide variations in usual and customary rates and allowed amounts between health plans as well as different interpretations of the term usual and customary so other terminology should be used wherever possible. The OCC is committed to reimbursing providers using transparent reimbursement methodologies and is developing updated payment methodologies to be used when Medicare rate are not available or applicable.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 4: Provide parties responsible for reimbursing PC3/Choice and future community care program claims with usual and customary rate price schedules and a formal written policy on the proper application of those rates.

VHA Comment: Concur in Principle.

The Office of Community Care (OCC) will develop an updated payment methodology and written guidance on the proper use of the reimbursement rate methodologies and hierarchies. OCC is evaluating payment methodologies and hierarchies to reduce excessive reimbursement and is committed to reimbursing providers using transparent payment methodologies. OCC will develop more robust maximum allowable rate structures that are consistent with other federal healthcare programs and industry standards wherever practical. This will eliminate the need to create a usually and customary rate schedule. VHA agrees that a policy must be in place, so reimbursement amounts are consistent with strategies that minimize instances of paying billed charges.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 5: Establish controls for verifiable usual and customary rate payment methodology and establish a payment review process to ensure usual and customary rates are properly applied to the PC3/Choice and future community care program payments.

VHA Comment: Concur in Principle

VHA will no longer use usual and customary rate language within contracts. The – Patient Centered Community Care (PC3)/Choice contract will sunset on October 1, 2020. The Office of Community Care (OCC) is evaluating payment methodologies and hierarchies to reduce excessive reimbursement and is committed to reimbursing providers using transparent payment methodologies. OCC will develop rate structures consistent with other federal programs and industry standards and create and implement reimbursement methodologies that avoid excessive reimbursement. This will eliminate the need to create a usually and customary rate schedule.

OCC concurs with the need to conduct oversight and establish controls to ensure accurate reimbursement methodologies are applied, and reimbursement is not in excess or defaults to billed charges. To ensure proper payment to community providers, the Community Care Network (CCN) contract requires Third Party Administrators (TPAs) to hire an independent audit firm to perform recovery recoupment audits on a quarterly basis. Additionally, CCN payments are subject to the Payment Integrity Information Act annual review. By ensuring accuracy of payment by TPA's to providers, payment controls are focused on the front end of the payment cycle and inserts accountability to ensure contractors processing claims on behalf of VA do so at a high degree of accuracy.

Reimbursement to the TPAs to process claims on behalf of VHA, are executed using an automated reimbursement system. This Community Care Reimbursement System (CCRS) efficiently and effectively reimburses TPAs and introduces several automated controls to ensure reimbursement to the TPA is accurate and conforms to the contract. Controls include authorization matching, duplicate logic, and List of Excluded Individuals/Entities.

Another strategy VHA is implementing to insert greater oversight and internal controls includes using data analytics to monitor the accuracy, consistency, and relevance of healthcare reimbursement and to identity areas where excessive payments (including claims paid at or near bill charges) are occurring so that mitigation plans can be put in place to conserve healthcare benefit dollars. To demonstrate completion of this recommendation VHA will provide audit results, from independent CCN audit firm, CCRS audit and the Post Payment Analytics & QA Plan and results of audits performed.

Status: In Progress Target Completion Date: December 2020

OIG Recommendation 6: Ensure payment-rate schedules used by the Plexis Claims Manager and future payment systems to support the PC3/Choice and future community care contracts are current, accurate, and complete to prevent overpayments.

VHA Comment: Concur in Principle

It is critical that payment rate schedules and hierarchies used in claims processing and payment systems are current, relevant, accurate, and complete. However, VHA was not provided enough information on the claims sample utilized by OIG for analysis or specific details regarding the subsequent cost saving calculations computed by OIG that were based on the 253 claims in the sample. We found some of the examples referenced by OIG as errors in the report (for example procedure codes 92015 and 97811) were paid appropriately using the TPA's invoiced amount as these services did not have a Medicare rate at the time services were rendered and therefore defaulted to reimbursing the lesser of the VA Fee Schedule or billed charges. These differences call into question the dollar amounts of overpayments, errors and cost saving opportunities referenced throughout the OIG report. VHA cannot validate the value of overpayments but are confident it is significantly less than reported in this audit.

With the implementation of the recovery audit contract, current Financial Services Center post audits, and enforcement of strict standards within new contracts (Community Care Network), VA has established controls to prevent overpayments, while putting mechanisms into place to recapture overpayments. The Office of Community Care will develop an updated payment methodology and written guidance on the proper use of the reimbursement rate methodologies and hierarchies.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 7: Ensure that the Office of Community Care determine an appropriate reimbursement process for the identified pass-through errors.

VHA Comment: Concur

Three pass-through errors were identified in the audit, one of which was already refunded on April 3rd, 2019. The other two pass-through errors have been identified and will be included in the Healthnet Patient Centered Community Care (PC3) contract closeout reconciliation. VHA will request closeout of this recommendation once the HealthNet contract closeout is completed.

Status: In Progress Target Completion Date: March 2021

OIG Recommendation 8: Ensure the Office of Community Care establishes formal policies and procedures to identify and recover overpayments from PC3/Choice third-party administrators for improperly billed claims.

VHA Comment: Concur

Over the past several years significant changes have been made in VHA processes related to controls and oversight based on previous OIG recommendations. VHA has applied lessons learned to transition claims and reimbursement systems for Patient Centered Community Care (PC3) from a highly manual, inefficient and problematic system to one that leveraged greater efficiency. The findings of this audit concerning improper payments demonstrate a substantial improvement over prior audit findings. Because of the improvements VHA has made, there were very few errors identified in this Choice/PC3 audit. The Office of Community Care will continue to improve processes and internal controls to ensure payments made to Third Party Administrators (TPA) and to community providers demonstrate quality and cost effectiveness to ensure good financial stewardship.

VHA will recover overpayments from the TPA after the audit data is validated and overpayments are confirmed. Claims identified in the audit related to pass-through are addressed in Recommendation 7. If the errors related to Medicare reimbursement schedules noted in Recommendation 6 are confirmed as an overpayment, VHA will recover funds from the TPA, who will then be required to recoup from the community provider. VHA will issue bills of collection. If overpayments cannot be validated and quantified, VHA will request closure of this recommendation.

Status: In Progress Target Completion Date: March 2021

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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