DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor

AUDIT | REPORT #19-06902-23 | MARCH 2, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to determine if a contractor accurately processed claims for non-VA healthcare services. Non-VA health care is provided in the community. VA authorizes care from non-VA providers based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans. Claims for non-VA care must be submitted and approved for VA to pay them. If claims are not processed correctly, veterans may be billed for care that VA should have covered. VA has worked with contractors to process the claims since 2014.

A confidential complainant made allegations in 2019 that employees of the contractor Signature Performance incorrectly processed more than 100,000 claims for non-VA care. The complainant also alleged that employees in VA's Payment Operations and Management directorate (part of the Veterans Health Administration's Office of Community Care) needed to correct claims that the contractor's employees had incorrectly processed. Payment Operations and Management and contractor employees both process claims, but they may perform different processing tasks for the same claim.

What This Audit Found

The objective of the contract between VA and Signature Performance was to process non-VA medical care claims, including the review and determination of proposed payment of claims. The contractor's employees assisted VA employees in processing non-VA medical care claims due to the rapid increase in the volume of claims, according to the VA contracting officer. The contract included a schedule of services to pay the contractor for conducting claims actions.[1] The schedule of services sets out the amount VA pays for the services it purchased through the contract, including claims actions related to verification, distribution, and payment decisions.

How non-VA healthcare claims are processed can potentially shift the financial burden of health care from VA to veterans, and is ultimately VA's responsibility even when it uses contractors. Although VA employees must follow Office of Community Care guidance when processing non-VA medical care claims, the contract did not specifically require the contractor's employees to follow the same Office of Community Care guidance when processing claims. Moreover, the contract did not include standardized criteria for the contractor's employees to use when distributing and processing claims.

Although the contractor cannot be faulted for acting inconsistently with Office of Community Care guidance or other VA criteria that were not required in its contract, the resulting inconsistencies mean VA lacks assurances that proper processes were used. If claims are

[1] Contract Number VA791-14-D-0028.

inaccurately processed and not approved by VA, there is a chance that the non-VA provider will bill the veteran for the care.[2]

Due to the lack of processing criteria within the contract, the audit team assessed the claims processed by Signature Performance based on the same guidance used by the Office of Community Care staff to identify processing errors stated in the allegation received by the OIG. The audit team reviewed a statistical sample of 253 non-VA care claims that VA received during the first two quarters of fiscal year 2019. The team identified issues in two categories:

- **Rendering a decision** includes carrying out tasks such as reviewing claims, suspending claims, making the final decision on the claim (reject, deny, or accept), and determining payment.[3]
- **Distribution** involves identifying the correct legal authority for the claim, if any.[4]

Based on a statistical sample, the audit team determined the contractor distributed or rendered decisions for an estimated 10.3 million unique non-VA care claims it handled during the audit's six-month review period.[5] A unique claim could have more than one claim action completed by the contractor's employees, including verifying, distributing, or rendering decisions, or a combination of these actions. Of the 10.3 million unique claims, the audit team estimated that the contractor's employees rendered a decision for an estimated 5.5 million claims and distributed an estimated 9.8 million claims. Based on the statistical sample, the audit team estimated that 13 percent of the 5.5 million claims had rendered decisions that did not align with Office of Community Care guidance, as illustrated in figure 1.

[2] The audit team could not determine whether providers billed veterans for inaccurately processed claims that VA did not reimburse.

[3] When a claim is accepted, it meets criteria that allow the claim to be paid. When a claim is denied, it is because there is not a basis for a payment. A claim may also be rejected, which means that it cannot be decided until the claimant provides additional or corrected information. Reasons to suspend a claim, or place it on hold, include the need for a coding or clinical review. A review determines if the claim should be paid, and if so, by what legal authority—authorized, unauthorized, or Mill Bill—the claim should be processed for payment.

[4] VHA Office of Community Care, Operational Guidebook, chap. 4, sec. 4.2.1.2, "Distribution," modified February 5, 2018.

[5] The audit team reviewed a statistical sample of 253 accepted, denied, and rejected non-VA care claims (of the 10.3 million total unique claims for that period) that were scanned or electronically received from October 1, 2018, through March 31, 2019, and projected the results to the population.

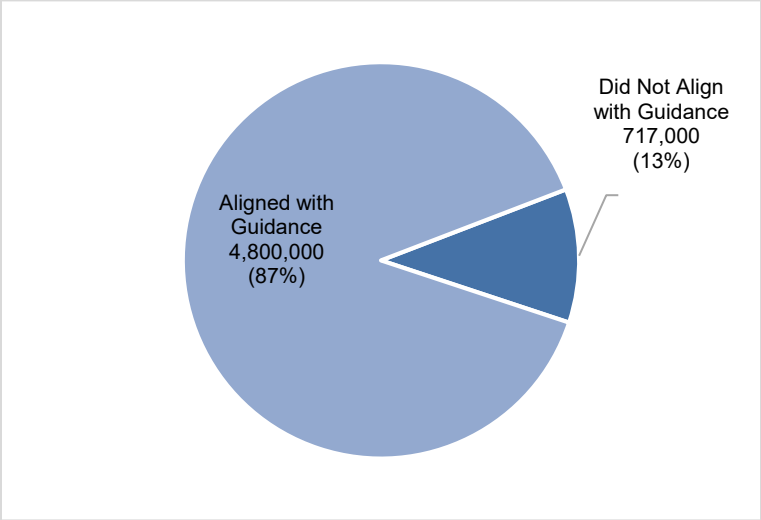

Figure 1. *Claims decisions for 5.5 million Signature Performance claims as compared with Office of Community Care guidance.*

Source: VA OIG analysis of projected sample results of non-VA care claims processed by Signature Performance.

Inconsistencies and errors do not necessarily mean that the final claim decision was inaccurate. For example, a claim could be rejected for the wrong reason, but the overall decision to reject the claim was correct.

There are also costs associated with the individual actions taken by the contractor, based on the schedule of services outlined in the contractual agreement between VA and Signature Performance, which details the cost of specific claims processing support actions. Although the contract identified the amounts to be paid to the contractor, it did not require that the actions be performed in accordance with Office of Community Care guidance. The contractor's claims decision (adjudication) processing actions identified during the period of this data review that did not align with Office of Community Care guidance were valued at an estimated $3.6 million over the six-month audit review period.

The audit team determined that the contractor's employees distributed about 10 percent of the 9.8 million claims without correct authorization or stated legal authority when assessed against Office of Community Care guidance. According to Office of Community Care guidance, voucher examiners are responsible for selecting the correct authorization within the Fee Basis Claims System when processing non-VA care claims. The audit team determined that in some instances, the contractor's employees attached the wrong authorization to claims. This action does not mean the final decision is wrong, but it is important because it could negatively affect the decision on other claims for which the authorization was intended or create a risk of paying an unauthorized claim. A claim that was distributed to the wrong legal authority may be corrected by another employee later in the claims process. Office of Community Care guidance also states that voucher examiners should select the appropriate legal authority during

distribution based on the patient's service connection. Incorrect distributions do not directly lead to an incorrectly decided claim, but increase the risk of errors, delays, or rework.

The inadequate contract terms and lack of effective oversight by the Veterans Health Administration (VHA) contributed to the problems identified in the OIG audit:

- **No claims processing guidance.** The executive director of delivery operations confirmed the contractor was not required to follow Office of Community Care guidance.[6] Because VA failed to establish a requirement in the contract to follow claims processing guidelines, the Office of Community Care staff assumes the burden for identifying and correcting errors when claims are processed inaccurately.
- **Failure to align contractor's standard operating procedures with VA guidance.** The contractor's standard operating procedures included guidance that did not align with Office of Community Care guidance. The objective of the contract was for contract staff to completely process non-VA medical care claims (that is, review and determine the proposed payment). The audit team found the contractor created its own standard operating procedures from Office of Community Care guidance for each Veterans Integrated Service Network (VISN) and maintained the procedures on the contractor's internal website. Payment Operations and Management employees did not have access to this internal website, and some managers were not aware of how updates to the procedures were made. Signature Performance personnel, however, stated they shared their VISN standard operating procedures annually with Payment Operations and Management managers for review. The executive director of delivery operations confirmed that the contractor maintained VISN-specific guidance (as allowed by the contract) that contained nuanced differences.
- **Inadequate contract oversight of quality reviews.** The contracting officer's representative in the Office of Community Care was required to review all claims processed by the contractor to ensure the 98 percent accuracy standard in the contract was met. This requirement was part of the contract's quality assurance surveillance plan. The plan also required that VA perform at least an annual review to determine if changes were needed. In addition, the contracting officer was responsible under the plan for ensuring compliance with other contract terms. However, the Office of Community Care contracting officer's representative did not ensure that Signature Performance employees met claims accuracy requirements or recommend changes to a more realistic standard, and the contracting officer did not ensure compliance with contract terms. The contracting officer explained that the plan was not feasible, but it was not adjusted

[6] The contract stated that "site specific guidance will be provided to the contractor." There was no requirement in the contract to follow such guidance.

because the primary focus for VA was administering the contract to assist with the rapid increase in the volume of claims.

- **VA quality assurance deficiencies.** The audit team determined that Payment Operations and Management employees did not audit Signature Performance claims until February 2019, more than four years after the contract was awarded. According to a Payment Operations and Management program management officer, there was no official quality reporting mechanism in place prior to February 2019. However, the contract awarded in September 2014 required VHA leaders to analyze and audit claims.

  When a quality issue was identified with the contractor's employees, it was generally addressed informally, such as with a phone call. According to Office of Community Care personnel, collaboration occurred between the contractor and VA through individual and conference calls to discuss training, quality, and error findings. The Office of Community Care's Business Integrity and Compliance Division also did not specifically audit Signature Performance's processing of claims prior to 2019. The national quality assurance program manager stated there were no policies in place requiring audits of the contractor by Payment Operations and Management employees.

- **Inconsistent application of internal procedures.** The audit team found contract and Payment Operations and Management employees used different reasons to deny and reject similar claims. Employee training on determining which reasons to use was not provided. The Payment Operations and Management national quality assurance program manager said that some of the denial and rejection reasons potentially conflict, and that staff may be confused about when to select which reasons. While assessing claims acted on by Signature Performance employees, the audit team also found Payment Operations and Management employees inaccurately denied claims without evidence of a clinical review as required by processing procedures.

VHA agreed with the OIG that the contract allowed Signature Performance "to process non-VA claims variably according to site-specific practices, as opposed to what VHA should have established—one standard for processing claims at all sites." VHA agreed that oversight of the contractor's performance was not robust and stated that it has strengthened oversight processes of non-VA care claims.

In May 2020, VHA's Business Integrity and Compliance Department of Internal Audits reported on its audit of claims adjudicated by Signature Choice and identified similar issues to those

raised by the OIG.[7] That internal audit concluded that nearly 18 percent of claims reviewed were not processed by the contractor in accordance with Office of Community Care guidelines. The internal audit report noted that some of the key factors contributing to the issues were insufficient review of authorizations, discrepancies in the contractor's standard operating procedures, and lack of a national standard operating procedure.

What the OIG Recommended

The OIG made six recommendations to the under secretary for health.[8] The recommendations were that the Payment Operations and Management directorate reevaluate and correct as needed all sample claims not processed in accordance with Office of Community Care guidance, make full use of the established communications tracking tool, provide training and additional guidance to its staff and the contractor's employees on using standardized denial and rejection reasons, and ensure employees follow procedures to process claims with no authorizations in order to process these claims consistently and accurately. Also included was a recommendation to ensure there was a contract requirement that contractor employees must follow Office of Community Care guidance for processing non-VA care claims, and that the contractor's standard operating procedures for claims processing are accurate and reflect current Office of Community Care procedures. The last recommendation was that the Office of Community Care develop and implement clear controls for reviewing and updating, if necessary, the quality assurance surveillance plan requirements at least annually.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred or concurred in principle with the recommendations and provided corrective action plans that are responsive to the intent of the recommendations. The executive in charge stated that VHA considers recommendations 2, 3, and 6 fully implemented and asked the OIG to consider closing them. Appendix D includes the full text of the executive in charge's comments.

The OIG reviewed the responses and supporting documentation submitted for the recommendations and considers recommendation 6 closed. Recommendation 2 will be closed when VHA provides evidence that the contract language states that the contractor must follow

[7] A new contract with Signature Choice was signed on March 6, 2019. Signature Choice is a joint venture between the initial contract awardee Signature Performance and Principle Choice Solutions, a service-disabled veteran-owned small business. The OIG notes that the new contract provides more direction to the contractor, but greater clarity is needed regarding mandatory requirements the contractor must follow in processing claims and the specific VA internal control requirements that the contractor must meet.

[8] Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary's functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

guidance set forth in the contract, and that said guidance for processing all types of claims is the same for both the contractor and Office of Community Care staff. The OIG will close recommendation 3 after VHA satisfies recommendation 2 and when it provides evidence that the Electronic Claims Administration and Management System is able to accurately distribute claims.

The OIG will monitor the implementation of all planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.

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Contents

Abbreviations

CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
FY	fiscal year
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

VA provides health care to veterans through community providers when VA facilities cannot provide the needed services. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual veterans. Claims for non-VA health care need to be submitted and approved for payment. Both VA employees and contractor employees process claims for non-VA care.

In 2019, a confidential complainant alleged that the contractor Signature Performance failed to correctly process over 100,000 non-VA care claims. Moreover, this caused Payment Operations and Management employees in the Veterans Health Administration (VHA) Office of Community Care to fix claims that Signature Performance employees incorrectly processed. Inaccurate claims processing can potentially shift the financial burden from VA to the veteran if healthcare claims are erroneously denied. The VA Office of Inspector General (OIG) conducted this audit to assess the allegation by determining whether the contractor's employees were accurately processing non-VA care claims.

A related OIG audit released in 2019 focused only on VHA employees and non-VA emergency care claims. That audit determined that VHA's Payment Operations and Management employees inappropriately processed an estimated 31 percent of non-VA emergency care claims from April 1 through September 31, 2017.[9]

Responsibilities of VA and Contractor Employees

Payment Operations and Management and contractor employees both process claims, but they may perform different processing tasks for the same claim. Either type of voucher examiner can be responsible for verifying, distributing, or rendering a decision on a claim, as discussed more fully in the claims review process section below. Per the contract performance work statement, when claims are received by the local VA medical center or consolidated payment center, they are put into VA's claims processing system and processed by administrative staff for payment to the appropriate healthcare provider. The objective of the agreement is for contract staff to process non-VA medical care claims (that is, review them and determine the proposed payment).

Payment Authorities

Federal law authorizes payment or reimbursement to a claimant for non-VA care received by veterans meeting specific eligibility criteria.

[9] VA OIG, *Non-VA Emergency Care Claims Inappropriately Denied and Rejected*, Report No. 18-00469-150, August 6, 2019.

Three provisions of the law give VA the authority to pay non-VA care claims:

- 38 U.S.C. § 1703 defines the requirements for the contracting of "authorized" non-VA care (authorized claims).
- 38 U.S.C. § 1728 defines the requirements for VA's reimbursement of "unauthorized" care claims (unauthorized claims) for service-connected disabilities.
- 38 U.S.C. § 1725 defines the requirements for reimbursement of "unauthorized" care claims for nonservice-connected conditions (Millennium Bill or "Mill Bill" claims).

Claims Review Process

The claims process begins when a claim is submitted either electronically or on paper for processing through the Fee Basis Claims System, a system of record for non-VA care claims adjudication. The claim is then verified and linked to a payment authority, and a decision is rendered. These actions may be completed by voucher examiners from either Payment Operations and Management or Signature Performance. For example, the contractor's employee could be responsible for distributing the claim, and then a Payment Operations and Management employee could be responsible for rendering the correct claim decision on the same claim. Alternatively, Payment Operations and Management's or the contractor's voucher examiners could be responsible for multiple claim actions on the same claim.

Verification

When a claim is submitted on paper, employees are responsible for sorting, scanning, and uploading the claim and associated information into the Fee Basis Claims System "verify" module. This module populates the fields with the information from the claim and looks for questionable fields (possible inaccuracies), prompting employees to correct the text. Once the information in the fields has been confirmed, the voucher examiner moves the claim to the Fee Basis Claims System distribution and processing module for further review. In contrast, when a claim is submitted and received electronically, the verify module is bypassed, and the claim goes directly to the Fee Basis Claims System distribution module.

The audit team found that Signature Performance staff did not verify any of the claims sampled. During the data review period, Signature Performance was reimbursed for claims verification for a minimal number of claims, according to data provided by the contracting officer's representative. The representative agreed that the claims action of verification started to decrease in August 2018 because another third-party contractor converted paper claims to electronic claims, which reduced the need for Signature Performance employees to verify claims.

Distribution

The distribution module acts as an electronic mail room and circulation center for newly received claims.[10] The primary function of this module is for voucher examiners to link the claim to a veteran and a legal authority for potential payment. In the distribution module, voucher examiners are presented with potential legal authorizations that may correspond to the specific claim. The voucher examiner should select the matching authorization if it is available. Figure 2 outlines the criteria that need to be met to assign the appropriate legal authority.

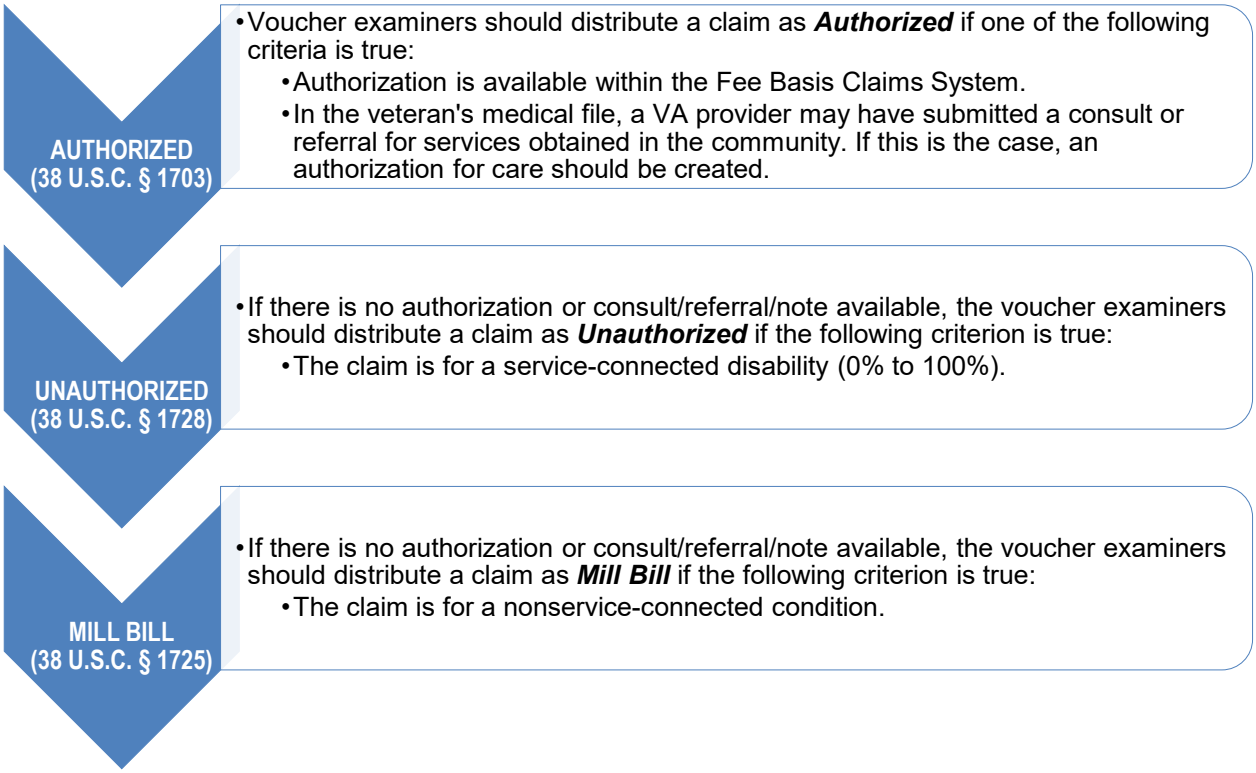

Figure 2. *Distribution procedures to process authorized, unauthorized, and Mill Bill claims.*

Source: VA OIG analysis of Office of Community Care distribution procedures.

Claims Decisions

Employees research and render decisions on claims using the processing module in the Fee Basis Claims System. Research includes the following:

- Detailed authorization review to compare services authorized and services rendered

[10] VHA Office of Community Care, Operational Guidebook, chap. 4, sec. 4.2.1.2, "Distribution," modified February 5, 2018.

- Administrative and clinical eligibility review[11]
- Billing and coding review
- Payment amount determination for applicable claims

Based on this research, voucher examiners can accept, deny, reject, or suspend claims. A claim is accepted if it meets specific criteria for payment and is denied if it does not meet these criteria. Claimants may appeal denied claims. Voucher examiners should reject a claim when it cannot be processed for reasons such as the failure to submit required documentation with the claim. Rejected claims may be resubmitted with the previously missing information. Reasons to suspend a claim, or place it on hold, include the need for a coding or clinical review.

Claims Processing Support Contracts

Since 2014, VHA has entered into contracts to assist with processing non-VA care claims. Several contributing factors led to the need for claims processing support contracts, including a growing backlog and an increase in the volume of claims, according to a Payment Operations and Management program officer.

VA awarded a claims processing support contract to Signature Performance in September 2014, which included one base year and up to four option years.[12] According to Payment Operations and Management data, VA paid over $140 million for Signature Performance claims processing activities since January 2015, and Signature Performance's workload had increased dramatically since the contract was awarded.[13] Specifically, during fiscal year (FY) 2016, VA paid about $13 million for 3.7 million claims processing activities of verification, distribution, and claims decisions. This increased to about $46 million for 17.7 million claims activities during the first two quarters of FY 2019. Performance on the initial contract with Signature Performance ended on April 12, 2019, according to the contracting officer's representative.

A new contract with Signature Choice was signed on March 6, 2019. Signature Choice is a joint venture between the initial contract awardee Signature Performance and Principle Choice Solutions, a service-disabled veteran-owned small business. Performance under the newly established contract did not begin until the first task order was issued on April 13, 2019, according to the contracting officer's representative. The audit team only assessed Signature Performance claim actions that were taken under the first contract that was awarded to Signature

[11] Administrative and clinical eligibility reviews are for claims that were not previously authorized. A review determines if the claim should be paid, and, if so, by what legal authority the claim should be processed.

[12] Contract Number VA791-14-D-0028.

[13] The contracting officer's representative was told that although the contract was awarded in September 2014, performance on the contract did not begin until January 2015 due to training and system access needs.

Performance because insufficient time had elapsed to assess the performance under the new contract.

Results and Recommendations

Finding: The Contractor Did Not Always Process Claims in Accordance with the Office of Community Care Guidance as Consistency Was Not Required by the Contract

The Office of Community Care was responsible for conducting adequate contract surveillance and quality assurance to ensure contract requirements for claims processing were satisfactorily completed and performance measures were met or exceeded, according to the contract with Signature Performance. The audit team determined the contractor's employees rendered decisions that did not align with the Office of Community Care guidance for about 13 percent of non-VA care claims that these employees handled. In addition, the audit team identified the contractor's employees distributed about 10 percent of non-VA care claims either without a correct authorization or to a different legal authority than the Office of Community Care's guidelines indicated. Although VA employees must follow Office of Community Care guidance when processing non-VA medical care claims, the contract did not specifically require the contractor's employees to follow the same Office of Community Care guidance when processing claims. These issues were not detected due to inadequate contract oversight by the Office of Community Care and the contracting officer, quality assurance deficiencies, and inconsistent application of internal procedures.

The contractor cannot be faulted for acting inconsistently with Office of Community Care guidance because complying with the guidance was not required by the contract. However, the resulting difference in practice means VA lacks assurance that proper processes were used. Deficiencies in processing and oversight increase the risk that veterans are unnecessarily billed. There are also costs associated with the individual actions taken by the contractor, based on the schedule of services outlined in the contractual agreement between VA and Signature Performance, which details the cost of specific claims processing support actions. The contractor's claims decisions (adjudication) that did not align with Office of Community Care guidance were valued at an estimated $3.6 million over the six-month audit review period.

What the OIG Did

The audit team reviewed a statistical sample of 253 accepted, denied, and rejected non-VA care claims of the 10.3 million total unique claims that were scanned or electronically received during the six-month period of October 1, 2018, through March 31, 2019. These claims were processed under either 38 U.S.C. §§ 1703 (authorized claims), 1728 (unauthorized claims), or 1725 (Mill

Bill claims).[14] The audit team only assessed Signature Performance claims actions that were taken during the first contract that was awarded to Signature Performance.

The audit team conducted a site visit to Signature Choice in Omaha, Nebraska, and interviewed more than 30 employees with direct knowledge of and responsibility for processing non-VA care claims.[15] In addition, the audit team reviewed Signature Performance's standard operating procedures, internal quality assurance program and associated records, and training program for processing non-VA care claims. The audit team also interviewed more than 30 Payment Operations and Management employees with knowledge of Signature Performance claims processing errors and Payment Operations and Management contract oversight responsibilities.

Signature Performance Employees Rendered Decisions That Did Not Align with the Office of Community Care Guidance

The audit team determined that Signature Performance acted on an estimated 10.3 million unique claims that were scanned or electronically received from October 1, 2018, through March 31, 2019.[16] A unique claim in the universe could have more than one claim action; actions include verifying, distributing, rendering decisions, or a combination of these actions. Of the 10.3 million claims, Signature Performance rendered decisions for an estimated 5.5 million claims and distributed an estimated 9.8 million claims.

- Rendering a decision involves researching the claim and adjudicating it as accepted, rejected, denied, or suspended.
- Distribution is the process of linking a claim to a veteran, matching an available authorization to the claim, and determining the appropriate legal authority.

The audit team determined the universe by identifying claims that were acted on by Signature Performance and at which point in the process (verification, distribution, or rendering a decision).[17] Due to the lack of processing criteria within the contract, the audit team assessed the claims processed by Signature Performance based on the same guidance used by Office of

[14] Included in the statistical sample were two claims that were processed without a legal authority.

[15] Signature Performance employees are colocated with the new Signature Choice employees in the same facilities in Omaha, Nebraska, used during the initial contract, according to Signature Performance's chief business development officer.

[16] The 17.7 million claim actions mentioned in the introduction include verification, distribution, and claims decisions. However, Signature Performance staff did not complete the verification action on any claims in the audit team's sample.

[17] The audit team only assessed Signature Performance claims actions that were taken during the first contract that was awarded to Signature Performance. The audit team projected the sample review results to the universe of non-VA care claims with claims actions made by Signature Performance.

Community Care staff to identify processing errors stated in the allegation received by the OIG.[18] Of the universe of claims, the audit team determined the following:

- Signature Performance employees rendered decisions that did not align with the Office of Community Care guidance for an estimated 717,000 of 5.5 million non-VA care claims (13 percent).
- Signature Performance employees distributed about 1 million of 9.8 million non-VA care claims (10 percent) without a correct authorization or to a different legal authority than the Office of Community Care's guidance indicated. These issues do not necessarily mean that the final claim decision was inaccurate, but they increase the risk of error, delays, or rework. For example, a claim that was distributed to the wrong legal authority may be corrected by another employee later in the claims process.

Overall, Signature Performance distributed or rendered decisions differently than indicated by the Office of Community Care guidance for an estimated 1.7 million of 10.3 million (16 percent) unique non-VA care claims it handled over the six-month audit review period.

Figure 3 illustrates the percentage of claims decisions aligned and not aligned with Office of Community Care guidance.

[18] The OIG notes that the new contract provides more direction to the contractor, but greater clarity is needed regarding mandatory requirements the contractor must follow in processing claims and the specific VA internal control requirements that the contractor must meet.

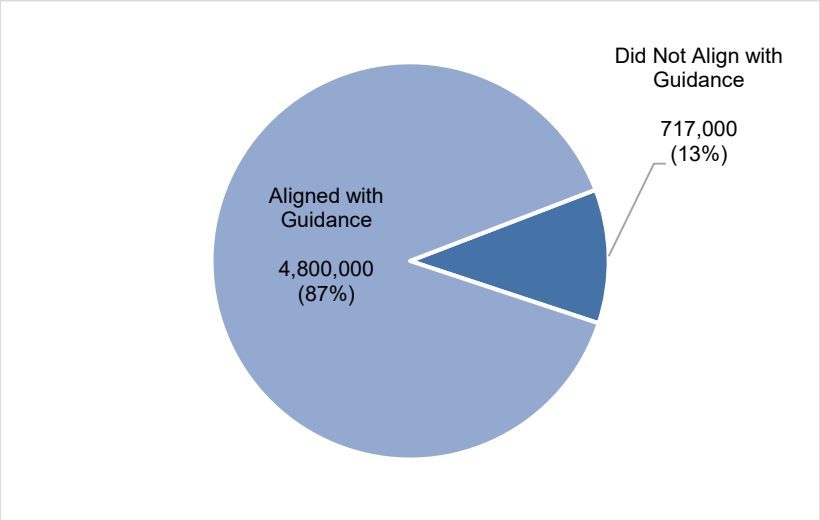

Figure 3. *Claims decisions for 5.5 million Signature Performance claims that had rendered decisions as compared with Office Community Care guidance.*

Source: VA OIG analysis of projected sample results of non-VA care claims processed by Signature Performance.

Over the course of the contract, VA spent over $140 million for Signature Performance to assist with claims actions, such as distribution and decision-making. From October 2018 through March 2019 alone, VA paid Signature Performance about $46 million. The schedule of services outlined in the contractual agreement between VA and Signature Performance details the cost of specific claims processing support actions. Although the contract identified the amounts to be paid to the contractor, it did not require that the actions be performed in accordance with Office of Community Care guidance. The audit team determined that the contractor's claims decisions identified that did not align with Office of Community Care guidance were valued at an estimated $3.6 million over the six-month audit review period.

The following sections and examples focus on how Signature Performance employees distributed and rendered decisions for non-VA care claims in ways that did not align with Office of Community Care guidance. Although the contractor cannot be faulted for acting inconsistently with Office of Community Care guidance or other VA criteria that were not required in its contract, the resulting inconsistencies mean VA lacks assurances that proper processes were used and point to opportunities for stronger oversight.

Contractor Did Not Identify Existing Authorization for Care

Based on errors identified in the sample, Signature Performance employees did not correctly identify an existing authorization for non-VA care.

When a claim is received, the voucher examiner is responsible for identifying any authorization that matches the care the veteran received, according to the Office of Community Care's guidance. Guidance further states that during the distribution stage, the voucher examiner is

responsible for accurately linking the claim to a veteran and legal authority based on the patient's service connection before the claim is routed to the Fee Basis Claims System processing module. Example 1 demonstrates that when voucher examiners do not identify the correct authorization for the care the veteran received, the claimant may be denied reimbursement for authorized care.

Example 1

A veteran received non-VA care on September 6, 2018. The audit team identified a VA authorization for this care that was effective from June 15, 2018, through December 13, 2018. However, on October 17, 2018, a Signature Performance employee did not identify and link the appropriate authorization to the claim during distribution, marking it unauthorized. This claim was ultimately rejected with the reason of "Authorization Absent (Home Health & Contractors)" by another Signature Performance employee on November 5, 2018. The audit team determined that because this care was authorized, the claim should have been paid, and the veteran was at risk of being billed by the non-VA provider. Signature Performance agreed that the appropriate authorization should have been attached to this claim during distribution.

Contractor Linked Incorrect Authorization for Care to Claims

In addition to not identifying an existing authorization, the contractor's employees also attached incorrect authorizations to claims. Voucher examiners are responsible for selecting the correct authorization within the Fee Basis Claims System, according to Office of Community Care guidance. This is important because when a voucher examiner attaches an incorrect authorization to a claim, the claim the authorization was intended for may be denied inappropriately because the authorization for the care was used for another claim, according to Payment Operations and Management's national quality assurance program manager. Attaching the correct authorization is also important because there is a risk a claim that was not authorized could be paid for with an incorrect authorization, according to a Training and Workforce Development training specialist. Office of Community Care guidance states that the voucher examiner should review the authorization prior to adjudication to ensure that the correct authorization was selected. Example 2 shows a claim processed with an incorrect authorization.

Example 2

A veteran received care for physical therapy on October 12, 2018. Signature Performance employees linked an authorization for orthopedic care to the claim instead of an authorization for physical therapy, and then paid the claim. According to Office of Community Care guidance, the linked authorization should have been reviewed prior to payment to ensure it was correct. Signature Performance and Payment Operations and Management employees agreed that

the incorrect authorization was selected. This presents a risk that if a claim for the same veteran is received for orthopedic care, it may be denied inappropriately because the authorization for care was used for another claim.

The audit team identified other instances of processing decisions that differed from Office of Community Care guidance that occurred to a lesser extent, including the following:

- Claims were distributed as authorized when they did not have an authorization.
- Claim was linked to the incorrect veteran.
- Claims were rejected for the wrong reasons.

Recommendation 1 addresses the need for the Payment Operations and Management directorate to reevaluate all sample claims identified in this audit as not processed in accordance with Office of Community Care guidance, and to take appropriate corrective action as needed.

Contract Did Not Include Claims Processing Guidelines

Inadequate contract terms and VHA's lack of effective oversight contributed to the issues identified. How non-VA healthcare claims are processed can potentially shift the financial burden of health care from VA to veterans, and is ultimately VA's responsibility even when it uses contractors. Although VA employees must follow Office of Community Care guidance when processing non-VA medical care claims, the contract did not specifically require the contractor's employees to follow the same Office of Community Care guidance when processing claims. Moreover, the contract did not include standardized criteria for the contractor's employees to use when distributing and processing claims. The executive director of delivery operations confirmed the contractor was not required to follow Office of Community Care guidance. The contract stated that "site specific guidance will be provided to the contractor." There was no requirement in the contract to follow such guidance. Because VA failed to establish a requirement in the contract to follow claims processing guidelines, the Office of Community Care staff assumes the burden for identifying and correcting errors when claims are processed inaccurately.

Recommendation 2 addresses the need for a requirement in the contract that the contractor's employees must follow Office of Community Care guidance for processing non-VA care claims.

Payment Operations and Management's Inadequate Oversight of Signature Performance's Standard Operating Procedures Increased Risk of Inaccurately Processed Claims

Signature Performance's standard operating procedures were often different from the Office of Community Care's guidance. Signature Performance maintains on its internal website its procedures for each of VHA's Veterans Integrated Service Networks (VISNs).

The objective of the contract with Signature Performance is to process non-VA medical care claims. Signature Performance initially provided claims processing support to a single VISN, according to Signature Performance's vice president of operations. Information for the initial VISN's standard operating procedure was provided by the VA training department, according to Signature Performance's chief business development officer.[19] She stated Signature Performance adapted this standard operating procedure by including more detailed instructions and then obtaining the VISN's concurrence with those changes. In addition, she said Signature Performance provided claims processing assistance for additional VISNs, then sent its original standard operating procedure to the additional VISNs for any needed changes that were VISN-specific.

Payment Operations and Management employees stated they did not have access to the internal website containing Signature Performance's VISN standard operating procedures.[20] The vice president of operations for Signature Performance said the contractor shares its VISN standard operating procedures annually with Payment Operations and Management managers for their review. However, the audit team found that some VISN managers stated that the procedures were not shared on a regular basis. Additionally, some VISN managers were not aware of how updates to the standard operating procedures were made.

When Signature Performance's standard operating procedures were compared with Office of Community Care guidance, the audit team found that in some cases Signature Performance's procedures were different. The executive director of delivery operations confirmed that the contractor maintained VISN-specific guidance that contained nuanced differences among the VISNs. VHA agreed with the OIG that the contract allowed Signature Performance "to process non-VA claims variably according to site-specific practices, as opposed to what VHA should have established—one standard for processing claims at all sites."

Example 3 illustrates differing procedures between the Office of Community Care and Signature Performance for distributing a claim.

Example 3

The Signature Performance standard operating procedures in VISN 10 stated that voucher examiners should distribute a claim without an authorization as "unauthorized" when the claim was for a veteran who was 50 percent service-connected or more. However, this is not consistent with the Office of Community Care's guidance, which instructs the voucher examiner to distribute a

[19] Payment Operations and Management did not verify or refute if this was how Signature Performance's standard operating procedures were initiated.

[20] Signature Performance management confirmed that Payment Operations and Management employees did not have access to the internal website.

> *claim without an authorization as unauthorized when the claim was for a veteran who has **any** service-connected disability. In addition, Signature's procedures in VISN 10 instruct a voucher examiner to distribute a claim as Mill Bill if the veteran is less than 50 percent service-connected, while the Office of Community Care's internal procedures require the claim to be distributed as Mill Bill if the veteran is nonservice-connected.*

The audit team determined that Payment Operations and Management employees did not ensure that Signature Performance's standard operating procedures aligned with Office of Community Care guidance. Additionally, the new contract with Signature Choice states "incorrect distribution decisions increase the risk of claim payment errors or delays, unnecessary suspensions and rework." Payment Operations and Management's inadequate oversight of Signature Performance's standard operating procedures increased the risk of staff inaccurately processing claims and veterans not receiving reimbursement for non-VA care.

Recommendation 3 addresses the need for Payment Operations and Management to make certain that the contractor's standard operating procedures regarding claims processing are accurate and implement a mechanism to ensure those procedures continue to reflect current Office of Community Care procedures to process claims.

The Office of Community Care Did Not Provide Adequate Contract Oversight of Quality Reviews

The contract required the Office of Community Care to analyze and audit claims that were processed by Signature Performance. As part of the contract, a quality assurance surveillance plan was established to provide "a systematic method to evaluate performance" of the contract and ensure VA received quality services. The plan required a 100 percent review of claims and a 98 percent accuracy standard. The plan also required at least an annual review to determine if changes were needed. The Office of Community Care contracting officer's representative, who was assigned to this contract during the scope of the audit team's data review, did not ensure tasks outlined in the plan were met.[21] According to the plan, if requirements were not met, the contracting officer was responsible for notifying Signature Performance of the failure, and the contractor was responsible for submitting a written appeal. Table 1 outlines the plan's tasks, performance targets, and responsible parties, and what the audit team determined had occurred.

[21] The contracting officer's representative discussed in this section was assigned to the contract in July 2018 and remained through the closeout of the initial contract.

Table 1. Quality Assurance Surveillance Plan Tasks—Expectations Versus Actual

Task	Performance standard and method of surveillance	Responsible party for ensuring task was met	What actually took place
Accurately enter medical claims data into Fee Basis Claims System. Contractor's employees are required to accurately process medical claims daily.	Claims will be 100% reviewed and 98% of data entered will be accurate.	Contractor and contracting officer's representative[22]	**Contractor:** Reviewed 2 to 3 percent of claims weekly. **Contracting officer's representative:** No review of claims processed by contractor's employees.
"To provide for changing quality assurance and quality performance conditions ... the components of QASP [quality assurance surveillance plan] measurement and reporting will be reviewed."	The components of plan measurement and reporting will be reviewed at least annually or more frequently if required.	Contractor and contracting officer's representative	The plan's measurements and reporting were never updated, according to the Payment Operations and Management contracting officer's representative.

Source: Audit team analysis of Signature Performance quality assurance surveillance plan for claims processing support.

The quality assurance surveillance plan requirements were established for a smaller number of claims, according to a contracting officer assigned to administer the contract.[23] To put this into perspective, Payment Operations and Management data indicated that for the first six months of claims processing, which took place from January 2015 through June 2015, Signature Performance verified, distributed, and rendered decisions for about 600,000 claims. This was a fraction of the claims workload compared to the six months of claims processing that took place from October 2018 through March 2019, during which Signature Performance verified, distributed, and rendered decisions for about 17.7 million claims activities. The contracting officer explained that as the claims volume grew, program management decisions were made to shift the volume of claims processing from Payment Operations and Management employees to Signature Performance employees.

[22] The VHA Procurement Manual defines a contracting officer as an individual duly appointed with specific authority to enter into, administer, and/or terminate contracts and make related determinations and findings on behalf of the US government. The manual defines a contracting officer's representative as a VHA employee nominated by a program office and appointed by the contracting officer with responsibility to monitor and evaluate contractor performance under a VHA contract.

[23] The contracting officer referenced was assigned to this contract from September 2016 through May 2019.

The contracting officer's representative said he did not assess Signature Performance claims for accuracy, adding that the 100 percent review requirement was not possible and could possibly entail "reviewing over one million claims per month." The representative also stated he did not have the ability to review 100 percent of claims because he did not have necessary access to the Fee Basis Claims System information for all processing facilities. The quality assurance surveillance plan held the contracting officer ultimately responsible for determining the adequacy of the contractor's performance; therefore, the contracting officer failed to meet the terms of the plan, as the quality review requirements were not met.

Per the quality assurance surveillance plan, Signature Performance was also responsible for reviewing 100 percent of claims. Instead, Signature Performance stated its quality assurance team was responsible for conducting sample reviews of 2 to 3 percent of claims weekly per voucher examiner, which amounted to about 5,000 to 7,000 claims audited per week. The vice president of operations for Signature Performance said its employees did not review 100 percent of claims because it believed Payment Operations and Management's Program Integrity Tool and the Quality Inspector Tool reviewed 100 percent of claims to meet the quality assurance surveillance plan requirement.[24] However, these tools are used only to review the accuracy of payment amounts of accepted claims, not whether the decision to accept, deny, or reject the claims was accurate.

The quality assurance surveillance plan also required at least an annual review to determine if revisions were necessary due to "changes in VA and contractor capabilities." This requirement is important given the dramatic growth in Signature Performance's workload. Based on the lack of contract documentation available, the audit team could not determine if the quality assurance surveillance plan was reviewed annually. The plan also specified the following:

> This [quality assurance surveillance plan] is a "living document" and the Government may review and revise it on a regular basis. The Government and Contractor will mutually agree on any revisions. Updates will ensure that the [quality assurance surveillance plan] remains a valid, useful, and enforceable document.

Despite this language, the contracting officer's representative said he did not initiate a dialogue with the contractor to change the terms of the quality assurance surveillance plan to a more reasonable review requirement. According to Signature Performance's vice president of operations, it was his understanding that the contracting officer's representative was to review the quality assurance surveillance plan. He said that during the contractor performance assessment report that was completed in May 2019 the issue was brought to his attention that the plan had not been updated since the beginning of the contract.

[24] The Program Integrity Tool identifies potential improper payments and the Quality Inspector Tool ensures payments are processed correctly.

The plan also held the contracting officer responsible for ensuring compliance with contract terms. The contracting officer said that it would have been reasonable to adjust the plan as the volume of claims increased. He explained that the plan was not adjusted because the primary focus was administering the contract for Signature Performance to assist with the rapid increase in the volume of claims. The contracting officer stated that as the claims volume grew, the program office's focus was on processing claims, as it was "responding to the needs of veterans" and feared that providers would stop providing care to veterans if claims were not timely processed.

On March 6, 2019, VA awarded a new contract to Signature Choice for claims processing support, which included a new quality assurance surveillance plan. The new plan still included the requirement for an annual VA review, but imposed less stringent quality assurance requirements. Specifically, the new plan does not require the contracting officer's representative and contractor to review 100 percent of claims. Rather, claims are subject to a sample review to determine if voucher examiners

- accurately assigned the VA payment authority during distribution,
- accurately applied the appropriate reason to deny or reject authorized or unauthorized claims, or
- correctly created a clinical tracking record if the claim was unauthorized.

To ensure that the plan "remains a valid, useful, and enforceable document," recommendation 4 addresses the need for the Office of Community Care to develop and implement clear controls for reviewing and updating, if necessary, the quality assurance surveillance plan requirements at least annually.

The Contracting Officer Did Not Adequately Administer and Document Contract Requirements

The audit team determined that the contracting officer did not ensure the electronic contract file included all relevant documentation. In addition, the contracting officer did not complete required contract performance assessment reports.

The contracting officer assigned to the contract in June 2019 stated that according to the Federal Acquisition Regulation, all pertinent information for the contract in regards to performance or issues should be loaded into VA's electronic contract management system.[25] The Federal Acquisition Regulation states that "documents on which action was taken or that reflect actions by the contracting office pertinent to the contract" are normally contained in the contract file.[26]

[25] VA's electronic contract management system allows users to access VA procurement actions.
[26] FAR 4.803(a)(40).

Furthermore, VHA procedures require the contracting officer's representative to provide the contracting officer with quarterly reports of the representative's assessment of the contractor's performance.[27] The audit team found that the electronic contract file was missing pertinent, required information. Specifically, components of the quarterly report, such as contracting officer and contracting officer's representative meeting documentation and contractor performance evaluation reports, were not available in the electronic contract file.[28] The contracting officer who was assigned to the project from September 2016 to May 2019 stated any contract documentation that he had would be available. However, when the audit team requested this documentation, the new contracting officer who was assigned to the contract in June 2019 confirmed that the electronic contract documentation was lacking or unavailable. VHA agreed that oversight of the contractor's performance was not robust and stated that it has strengthened oversight processes of non-VA care claims.

The VHA Procurement Manual states that a contractor performance assessment report is required to be completed by the contracting officer and the contracting officer's representative. Additional guidance says that the report will "systematically assess a contractor's performance" on a given contract during a specific time frame, provide a record "based on objective" facts, and be "supported by program and contract management data."[29] VHA stated that it found the contractor to have performed as expected to the standards of the contract. The contracting officer who was assigned to the project from September 2016 to May 2019 indicated that he did not recall if the contracting officer's representative completed quality assurance reports that pertained to the accuracy of Signature Performance's claims processing. Based on the review of available contractor performance assessment reports, the audit team concluded that the data used to measure contractor quality performance were not objective and were created and reported by the contractor, rather than VA.[30]

Payment Operations and Management Quality Assurance Audits Did Not Start until 2019

The *Claim Audit Standard Operating Procedure*, dated September 2019, states that VA quality assurance personnel will review a sample of claims adjudicated by both VA and contract team members. The procedure also says the purpose of the review is to determine if the claim was

[27] VHA Procurement Manual, part 801.603-70, "Contracting Officer Representative Standard Operating Procedures," March 11, 2019.

[28] According to VHA Procurement Manual 801.603-70, quarterly reports should contain documentation such as contracting officer's representative's contractor performance evaluation reports, quality assurance reports, invoices with tracking reports, and documentation for contracting officer and contracting officer's representative meetings.

[29] Contracting Performance Assessment Reporting System, "Guidance for the Contractor Performance Assessment Reporting System," July 2018.

[30] The audit team assessed four contractor performance assessment reports, from October 1, 2014, through September 30, 2019.

adjudicated correctly based on claim criteria. Payment Operations and Management audits of Signature Performance claims were not implemented until February 2019, according to the Payment Operations and Management's national quality assurance program manager. This was more than four years after the initiation of the contract. According to a Payment Operations and Management program management officer, there was no official quality reporting mechanism prior to February 2019. When a quality issue was identified with contractor employees it would be addressed informally, such as with a phone call. According to Office of Community Care staff, collaboration occurred between the contractor and VA through individual and conference calls to discuss training, quality, and error findings. The Payment Operations and Management national quality assurance program manager stated there are no policies in place mandating the audits of the contractor. However, the contract awarded in September 2014 required VHA leaders to analyze and audit claims.

The audit team also determined that the Business Integrity and Compliance Division, which conducts internal audits in the Office of Community Care, did not conduct any specific audits of claims processed by Signature Performance prior to 2019. The division had not specifically audited Signature Performance claims processing but had identified some claims in its other audit work that indirectly identified Signature Performance processing errors, according to the Business Integrity and Compliance deputy director. The deputy director stated that sometime between March and June 2019, Payment Operations and Management requested that the division's VA Community Care Special Audit Team audit Signature Performance claims. The deputy director believed this was requested due to the potential expansion of Signature Performance's workload. In May 2020, the division's employees completed the requested audit.

Payment Operations and Management Could Better Provide Feedback on Claims Processing Errors Made by Signature Performance Employees

In January 2019, Payment Operations and Management implemented a system for tracking communications related to internal controls and quality assurance between Signature Performance and Payment Operations and Management employees. The system was developed for Payment Operations and Management employees to communicate a claims-related issue or question to Signature Performance employees. According to Payment Operations and Management's national quality assurance program manager, about a month after the system was developed, Payment Operations and Management initiated a quality assurance mechanism for Payment Operations and Management staff to audit a sample of claims processed by Signature Performance employees for accuracy.

Results from these audits were intended to be captured on the quality tracking system by Payment Operations and Management staff so the errors were documented and Signature Performance employees could address them, according to the Payment Operations and

Management's national quality assurance program manager. He stated the use of this system was not mandatory but was highly encouraged, and guidance for using the system was provided verbally and via email. Employees stated that errors not added to the system were sometimes communicated over the phone or by email, if at all. The system categorizes errors as distribution, claims decision, or payment. Since January 2019, Payment Operations and Management's usage of the system has increased the volume of claims errors reported. However, VISNs reported significantly different numbers of errors from one another. For example, VISN 5 reported 15 claims errors, while VISN 23 reported 1,681 errors. The differences in reporting errors among VISNs can be attributed to a lack of compliance in using the tool, according to the national quality assurance program manager. A representative for VISN 5 attributed the VISN's low number of reported errors to its lack of audits of Signature Performance employees prior to October 2019, therefore not identifying potential errors to include in the tracker. From January 2019 through October 2019, Payment Operations and Management employees recorded over 7,500 Signature Performance claims processing errors in the tracker. Figure 4 illustrates the differences among VISNs.

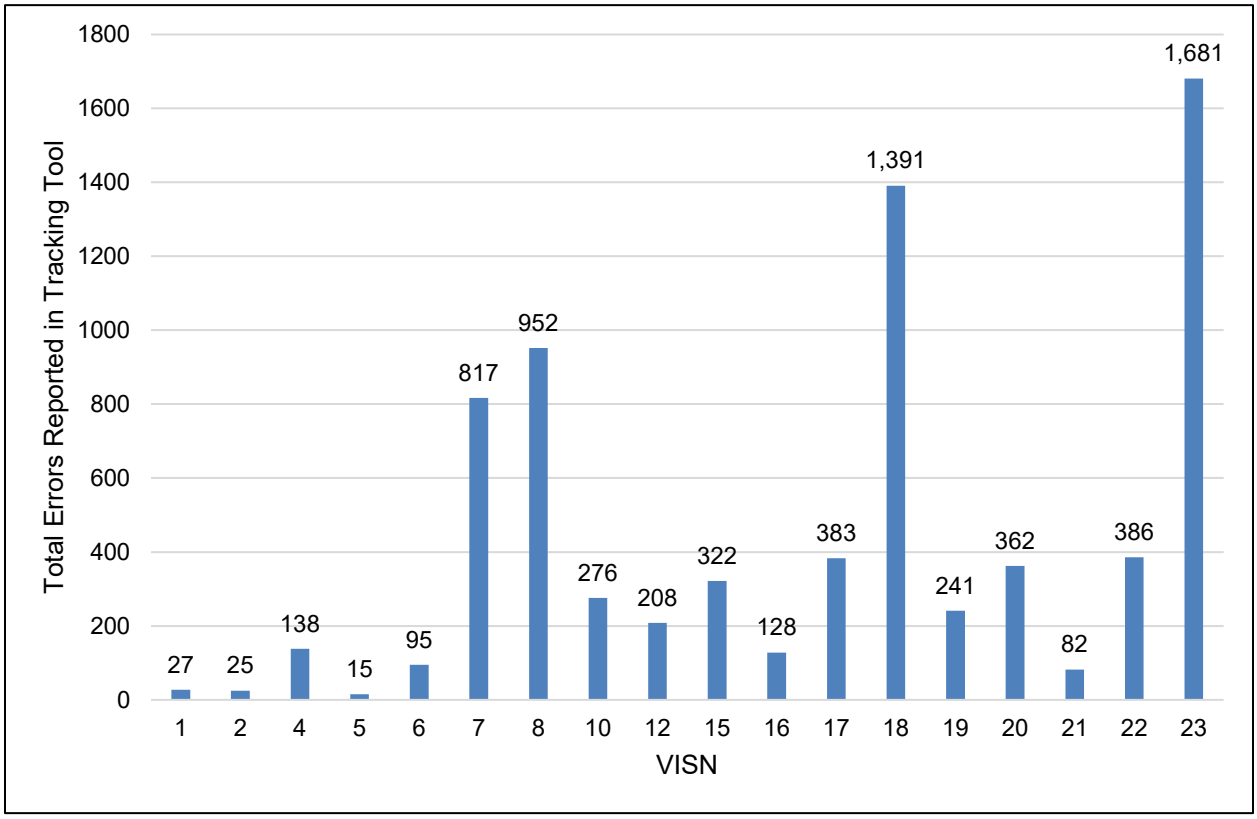

Figure 4. *Signature Performance errors reported in Payment Operations and Management's Communication Tracker Tool.*

Source: Errors reported in Payment Operations and Management's Communication Tracker Tool from January 11 to October 17, 2019.

Note: Some VISNs have merged over time so the numbering of VISNs is no longer sequential.

Signature Performance employees said not all Payment Operations and Management employees use this tracking system. Instead, contractor's employees receive emails from Payment Operations and Management employees regarding errors. Payment Operations and Management voucher examiners also indicated that they did not always communicate identified errors to their managers to be entered on the tracker because it was easier to fix the errors themselves and continue with their work.

The inconsistent communication between Payment Operations and Management and the contractor's employees regarding errors made by the contractor's employees increases the risk of inappropriately processed claims in the future. Recommendation 5 addresses the need for Payment Operations and Management personnel to make full use of the communication tracking tool.

The Office of Community Care Did Not Consistently Apply Internal Procedures for Processing Claims

The audit team found that guidance for adjudicating claims allowed voucher examiners to use different denial and rejection reasons for claims with fundamentally the same attributes. For example, according to standardized denial and rejection reason guidance, a claim for home health care without an authorization could be either denied for no prior authorization obtained or rejected for the reason "Authorization Absent (Home Health & Contractors)." The Payment Operations and Management national quality assurance program manager agreed that some of the denial and rejection reasons may potentially contradict each other, and that staff may be confused about when to select which reasons. He stated standard denial and rejection reasons were disseminated in various ways to Payment Operations and Management employees, but training for using these reasons was not provided. According to Payment Operations and Management staff, dissemination to regions along with a job aid is training. In addition, they stated that much of the training occurs at the payment center level.

The audit team also found that voucher examiners inaccurately denied claims that did not have evidence of a clinical review and listed the reason as "Prior Authorization Not Obtained." Office of Community Care guidance states when a claim does not have an authorization, a clinical tracking record should be created to research the claim and the veteran's record before staff document a final claim decision.

In addition, a supervisory training specialist's understanding of the process for claims that did not have an authorization was different than what was stated in Office of Community Care guidance. Specifically, she stated that when a claim does not have an authorization, voucher examiners can deny the claim without a clinical review for the reason of "Prior Authorization Not Obtained" if the care was for something other than emergency care. However, the Office of Community Care procedures state that when a claim does not have an authorization a clinical

review should be done, and the claim will be reviewed under either 38 U.S.C. §§ 1728 (unauthorized claims) or 1725 (Mill Bill claims).

Recommendation 6 calls on Payment Operations and Management leaders to provide training and additional guidance to their staff and contractor employees on applying and using standardized denial and rejection reasons, and to ensure that employees follow procedures to process claims with no authorizations in order to process them consistently and accurately.

In addition to the claims not processed in accordance with Office of Community Care guidance by Signature Performance employees, the audit team identified errors made by Payment Operations and Management employees while reviewing the contractor's work. The errors were similar to those identified in the OIG's prior audit of non-VA emergency care claims, as well as other newly identified errors.[31] The OIG reported in that prior audit that an estimated 31 percent of denied or rejected non-VA emergency care claims that were scanned or electronically received from April 1 through September 30, 2017, were inappropriately processed by Payment Operations and Management employees.

VHA's Business Integrity and Compliance Division's Review of the Contractor Yielded Similar Issues

In May 2020, the Business Integrity and Compliance Department of Internal Audits reported on its audit of adjudicated claims by Signature Choice and identified issues similar to those identified by the OIG. The internal audit concluded that nearly 18 percent of authorized claims reviewed were not processed by the contractor in accordance with Office of Community Care guidelines. The internal audit report noted that some of the key factors contributing to the issues were insufficient review of authorizations, discrepancies in the contractor's standard operating procedures, and lack of a national standard operating procedure.

The internal audit report noted that errors could be attributed to the lack of a national Signature Choice standard operating procedure, and lack of reconciliation between Signature Choice standard operating procedures and Payment Operations and Management desk procedures. The report also noted Signature Choice's documented standard operating procedures were not consistent nationwide and resulted in similar claims being processed differently depending on the VISN in which the claim was submitted.

Conclusion

The audit team determined based on its statistical sample that the contractor's employees rendered decisions that did not align with the Office of Community Care guidance for about 13 percent of non-VA care claims that these employees handled. In addition, the audit team

[31] VA OIG, *Non-VA Emergency Care Claims Inappropriately Denied and Rejected.*

identified the contractor's employees distributed about 10 percent of non-VA care claims either without a correct authorization or to a different legal authority than the Office of Community Care's guidelines indicated. These issues were not detected due to inadequate contract oversight by the Office of Community Care and the contracting officer, and occurred due to quality assurance deficiencies and inconsistent application of internal procedures. As a result, the contractor's claims decisions identified during the period of this data review that did not align with Office of Community Care guidance were valued at an estimated $3.6 million over the six-month audit review period. VHA acknowledged that oversight of the contractor's performance was not robust and stated that it has strengthened oversight processes of non-VA care claims.

The audit team determined that poor contract oversight increased the risk for inaccurately denied or rejected claims that could shift the financial burden of non-VA care from VA to veterans. Although the audit team could not determine whether care providers billed veterans for incorrectly denied or rejected claims that VA did not reimburse, the potential that exists for undue financial burden to veterans should be addressed.

Recommendations 1–6

The OIG recommended the under secretary for health ensures the following:[32]

1. The Payment Operations and Management directorate reevaluates all sample claims identified in this audit as not processed in accordance with Office of Community Care guidance, and takes appropriate corrective action as needed.
2. There is a contract requirement that the contractor's employees must follow Office of Community Care guidance for processing non-VA care claims.
3. The contractor's standard operating procedures for claims processing are accurate and a mechanism is put in place to keep the contractor's procedures updated to reflect current Office of Community Care claims processing procedures.
4. The Office of Community Care develops and implements clear controls for reviewing and updating, if necessary, the quality assurance surveillance plan requirements at least annually.
5. Payment Operations and Management personnel make full use of the established communication tracking tool.

[32] Recommendations directed to the under secretary for health were submitted to the executive in charge, who had the authority to perform the under secretary's functions and duties. Effective January 20, 2021, he was appointed to acting under secretary for health with the continued authority to perform the functions and duties of the under secretary.

6. Payment Operations and Management leaders provide timely training and additional guidance to their staff and the contractor's employees on applying and using standardized denial and rejection reasons, and employees follow procedures to process claims with no authorizations to ensure consistent and accurate claims processing.

Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with recommendations 1, 2, 4, and 5, and concurred in principle with recommendations 3 and 6. The executive in charge stated that the Office of Community Care recognizes the importance of claims payment and processing accuracy and agrees the contractor should have accurate standard operating procedures for claims processing.

To address recommendation 1, the executive in charge reported that the Office of Community Care will review the audit sample and take appropriate corrective action.

For recommendation 2, VHA's comments stated that the Office of Community Care will ensure the contractor is following Office of Community Care guidance for processing claims, and that the Payment Operations and Management office has developed a processing guidebook that contains all guidance in one document. The executive in charge also noted that the current contract directs the contractor to use Office of Community Care standard operating procedures for processing claims and indicates the contractor will use procedure guides provided by the Office of Community Care. VHA considered this recommendation fully implemented and asked the OIG to consider closing it.

As to recommendation 3, the executive in charge reported that the contractor uses guidance provided by the Office of Community Care. He said VHA has transitioned to a new claims processing system that is more automated, and the Office of Community Care developed a processing guidebook that optimizes contractors' ability to apply Office of Community Care claims processing procedures. He further stated that VHA considers recommendation 3 fully implemented and asked the OIG to consider closing it.

To address recommendation 4, the executive in charge concurred with reviewing and updating the quality assurance surveillance plan. He indicated the current plan is pending updates to remove functions specific to the Fee Basis Claims System as the system sunsets and modifies the measures for claims processing in the new processing system. He also said an annual meeting has been established to review the quality assurance surveillance plan.

For recommendation 5, the executive in charge reported that the communication tracking tool continues to be used by the Office of Community Care, ensures full visibility to potential claims issues, and fosters communication between staff and managers. He further stated that to ensure continuous improvement, the Office of Community Care will issue additional guidance to staff

on the usage and requirement of the communication tool, and VHA will communicate with leadership on an ongoing basis to confirm usage.

Finally, the executive in charge noted that for recommendation 6, the Office of Community Care has transitioned to the Electronic Claims Administration and Management System for claims processing, and the new system fundamentally changed how claims are processed and how standardization is controlled. He stated that local sites do not have the ability to adjust the denial reasons; therefore, usage of a nonstandard reason is no longer applicable. The executive in charge reported that the Electronic Claims Administration and Management System is an auto-adjudication system and does not require the step-by-step manual intervention that the Fee Basis Claims System required. To address the recommendation, the executive in charge indicated that the Office of Community Care Guidebook contains information on authorization edit codes, which provide detailed actions on how to review the claim to ensure consistent and accurate claims processing. The executive in charge concluded that VHA considers recommendation 6 fully implemented and asked the OIG to consider closing it.

OIG Response

The executive in charge's corrective action plans are responsive to the intent of the recommendations. The OIG reviewed VHA's response to recommendations 2, 3, and 6 and the supporting documentation submitted, and considers recommendation 6 closed.

Regarding recommendation 2, the OIG's review of documentation provided by VHA found that the contract does not state the contractor's employees must follow Office of Community Care guidance when processing all types of claims, only that guidance is provided. The OIG will close recommendation 2 when VHA provides evidence that the contract language states both that the contractor must follow guidance as stated in the contract, and that said guidance for processing all types of claims is the same for both the contractor and Office of Community Care staff. The OIG will close recommendation 3 after VHA satisfies recommendation 2, which entails ensuring that the guidance provided to the contractor, as referenced in contract documentation, is the same guidance that Office of Community Care voucher examiners adhere to, and when it provides evidence that the Electronic Claims Administration and Management System is able to accurately distribute claims.

The OIG will monitor the implementation of all planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix D includes the full text of the executive in charge's comments.

Appendix A: Background

According to the contract awarded on September 30, 2014, between the Office of Community Care and Signature Performance, contract employees were responsible for verifying, distributing, and rendering a decision for a minimum of 400,000 claims during the base year as of February 16, 2015. A contract modification effective May 16, 2018, increased the estimated monthly workload for distributing and rendering a decision for claims. The schedule of services set forth the amount VA paid for the services purchased through the contract, which included the cost associated with processing specific claims ordered under the contract for Non-VA Medical Care Program services. Table A.1 shows the estimated monthly workload for the period of performance from October 1, 2017, through March 22, 2019.

Table A.1. Estimated Monthly Workload

Description	Estimated quantity/monthly
Verification	N/A
Distribution	1,300,000
Rendering a decision	650,000

Source: OIG review of Signature Performance contract documentation.

Note: Signature Performance staff did not complete the verification action on any claims in the audit team's sample.

VA awarded another contract on March 6, 2019, to Signature Choice. Signature Choice is a joint venture between the initial contract awardee Signature Performance and Principle Choice Solutions, a service-disabled veteran-owned small business. Signature Performance employees are colocated with the newer Signature Choice employees in the same facilities in Omaha, Nebraska, used during the initial contract, according to Signature Performance's chief business development officer. The audit team did not review claims processed under this new contract.

The new contract is for community-based medical care claims processing for VA community care programs and expanded claims processing support services. The expanded support services include processing unauthorized and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) claims.[33] This is a firm-fixed-price, indefinite delivery-indefinite quantity contract with a base and four option years. Table A.2 shows the estimated annual claims in the base year total over 19.6 million actions. The contract maximum cost, inclusive of all options, is $500 million.

[33] CHAMPVA is a comprehensive healthcare program administered by the Office of Community Care in which VA shares the cost of covered healthcare services and supplies with eligible beneficiaries.

Table A.2. Base Year Schedule of Services

Description	Estimated quantity
Verification	30,840
Distribution	6,782,794
Authorized claims	4,050,000
Unauthorized claims	1,350,000
CHAMPVA claims	7,436,000
Total	**19,649,634**

Source: OIG analysis of Signature Choice contract documentation.

Prior OIG Report Findings and Recommendations

The OIG issued a report in August 2019 regarding non-VA emergency care claims inappropriately denied and rejected. The OIG found Payment Operations and Management employees inappropriately processed an estimated 31 percent of denied or rejected non-VA emergency care claims. Furthermore, Payment Operations and Management placed more emphasis on the number of claims processed than the accuracy of the claim decisions. Prioritizing production over quality stemmed from a backlog of unprocessed claims more than 30 days old, which Office of Community Care and Payment Operations and Management leaders tried to reduce. Additionally, Payment Operations and Management lacked sufficient quality controls. Standards for accurate claims processing were unofficial and inconsistently monitored from region to region. Other barriers affected claims processing as well. For example, a significant backlog in mail processing created a risk that veterans would not be informed of a claim decision or would be informed too late to resubmit or appeal. The OIG made 11 recommendations to the under secretary for health to address the issues identified.

Appendix B: Scope and Methodology

Scope

The audit team performed audit work from May 2019 through August 2020 to assess the accuracy of claims processed by Signature Performance employees. The audit scope was claims processed by Signature Performance staff during the first six months of FY 2019 (October 2018 through March 2019) under the authorities of authorized (38 U.S.C. § 1703), unauthorized (38 U.S.C. § 1728), and Mill Bill (38 U.S.C. § 1725).[34] In coordination with VA OIG statisticians, the team selected a statistical sample of accepted, denied, and rejected non-VA care claims that were scanned or electronically received. The audit team only assessed Signature Performance claims actions that were taken during the first contract that was awarded to Signature Performance.[35]

Methodology

To accomplish the objectives, the audit team

- reviewed applicable laws, regulations, policies, procedures, and guidelines regarding processing non-VA care claims;
- interviewed over 30 Payment Operations and Management employees with knowledge of Signature Performance claims processing errors and Payment Operations and Management contract oversight responsibilities (including the contracting officer's representative and Payment Operations and Management's national quality assurance program manager);
- conducted a site visit to Signature Choice in Omaha, Nebraska, and interviewed over 30 employees with direct knowledge of and responsibility for processing non-VA care claims;[36]
- examined contract documentation and Payment Operations and Management's quality assurance practices for Signature Performance-processed claims; and

[34] As part of the statistical sample, there were two sampled claims that were processed without a legal authority.

[35] According to the contracting officer's representative, although the second contract with Signature Performance was signed on March 6, 2019, performance under the newly established contract did not begin until the first task order was issued on April 13, 2019.

[36] Signature Performance and Signature Choice employees are colocated in the same Omaha-based facilities as they were during the initial contract. These interviews included Signature Performance's president and chief executive officer, vice president of operations, director of operations, and quality/training manager.

- reviewed Signature Performance's standard operating procedures, internal quality assurance program and associated records, and training program for processing non-VA care claims.

In coordination with VA OIG statisticians, the audit team reviewed a statistical sample of 253 accepted, denied, and rejected non-VA care claims and associated supporting documentation to determine if the claims were inappropriately processed by Signature Performance employees as alleged by a confidential complainant in 2019.[37] Appendix C provides more information on the audit team's statistical sampling methodology and results. For potential issues, the audit team discussed sample review results with Payment Operations and Management employees to provide clarification on questions and the identified potential issues.

The audit team used VHA's electronic record systems, Fee Basis Claims System snapshots of claims data and claims history, and relevant documentation to review the sample claims and assess whether the claims were processed accurately. The team projected and reported the sample results based on the results of its review. The team discussed the findings with Office of Community Care officials and included their comments where appropriate.

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, including

- reviewing patient and billing information of sampled claims, such as patient name and claim date of service, to verify whether the information was consistent with the veteran's information in the electronic health record;
- interviewing Signature Performance and Payment Operations and Management employees for potentially fraudulent activities within the scope of the audit; and
- soliciting the OIG's Office of Investigations to determine if there were any ongoing cases involving Signature Performance or the processing of non-VA care claims.

The audit team did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

The audit team relied on computer-processed data from VHA's Corporate Data Warehouse. To test for reliability, the audit team determined whether any data were missing from key fields,

[37] The audit team assessed a total of 253 non-VA care claims scanned or electronically received from October 1, 2018, through March 31, 2019. However, one claim was out of scope because the action taken by Signature Performance was not taken during the initial contract.

included any calculation errors, or were outside the time frame requested. The audit team also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or illogical relationships among data elements. The audit team compared claims documentation from VA's Fee Basis Claims System to claims data in VHA's Corporate Data Warehouse. The audit team concluded that the data obtained and relied on were sufficiently reliable for the purposes of this audit.

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 believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

To determine whether Signature Performance voucher examiners correctly verified, distributed, and rendered decisions for non-VA care claims, the audit team selected a statistical sample of accepted, denied, and rejected Uniform Bill (UB-04) and Health Care Financing Administration authorized, unauthorized, Mill Bill, and Service-Connected Emergency claims.[38]

Population

The sampling plan consisted of nine strata that included the following:

1. Authorized–Accepted Claims
2. Authorized–Denied Claims
3. Authorized–Rejected Claims
4. Mill Bill/Unauthorized–Accepted Claims
5. Mill Bill/Unauthorized–Denied Claims
6. Mill Bill/Unauthorized–Rejected Claims
7. Service-Connected Emergency Claims
8. Rejected claims with a blank legal authority
9. Claims with a billed amount greater than $2,000,000

The population consisted of 10,279,947 claims that Signature Performance employees made a claim action on that were scanned or electronically received from October 1, 2018, through March 31, 2019. Signature Performance employees are identified with the organization tag of (SIG) after their username. Claim actions are stamped by a user in the claim's history.

The audit team only assessed claim actions that were taken during the first contract that was issued to Signature Performance. The first contract issued to Signature Performance, Contract Number VA791-14-D-0028, was awarded on September 30, 2014. The second contract issued to Signature Choice, Contract Number 36C79119D0007, was signed on March 6, 2019.[39]

[38] The UB-04 claim is the official form used by hospitals and healthcare centers when submitting bills to Medicare and third-party payers for reimbursement for health services. The Health Care Financing Administration claim is the official standard form used by physicians and other providers when submitting claims for reimbursement to Medicare or Medicaid for healthcare services.

[39] According to a May 2019 document on Signature Performance's website, Signature Choice is a joint venture between Principle Choice Solutions, a service-disabled veteran-owned small business, and Omaha-based Signature Performance. The two companies have had a long-standing relationship, supported by aligned cultures, values, and a shared mission to reduce healthcare administration costs. Signature Choice has also engaged Omaha-based companies HDM and North End Teleservices to provide support on some elements of the program.

According to the contracting officer's representative, although the second contract with Signature Choice was signed in March 2019, claims processors did not handle claims under the newly established contract until the first task order was issued on April 13, 2019.

Sampling Design

To assess non-VA care claims, the audit team used a stratified random sample. From the population, the audit team sampled 253 non-VA care claims. The team sampled the following number of claims from each of the nine strata:

Table C.1. Sampling Design

Stratum	Count of sampled claims
1. Authorized–Accepted	62
2. Authorized–Denied	61
3. Authorized–Rejected	60
4. Mill Bill/Unauthorized–Accepted	13
5. Mill Bill/Unauthorized–Denied	7
6. Mill Bill/Unauthorized–Rejected	44
7. Service-Connected Emergency	2
8. Blank–Rejected	2
9. Greater than $2,000,000	2

Source: Sampling design constructed by the audit team and VA OIG statisticians.

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 statistician used the weights to compute estimates. For example, the OIG statistician 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 (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.

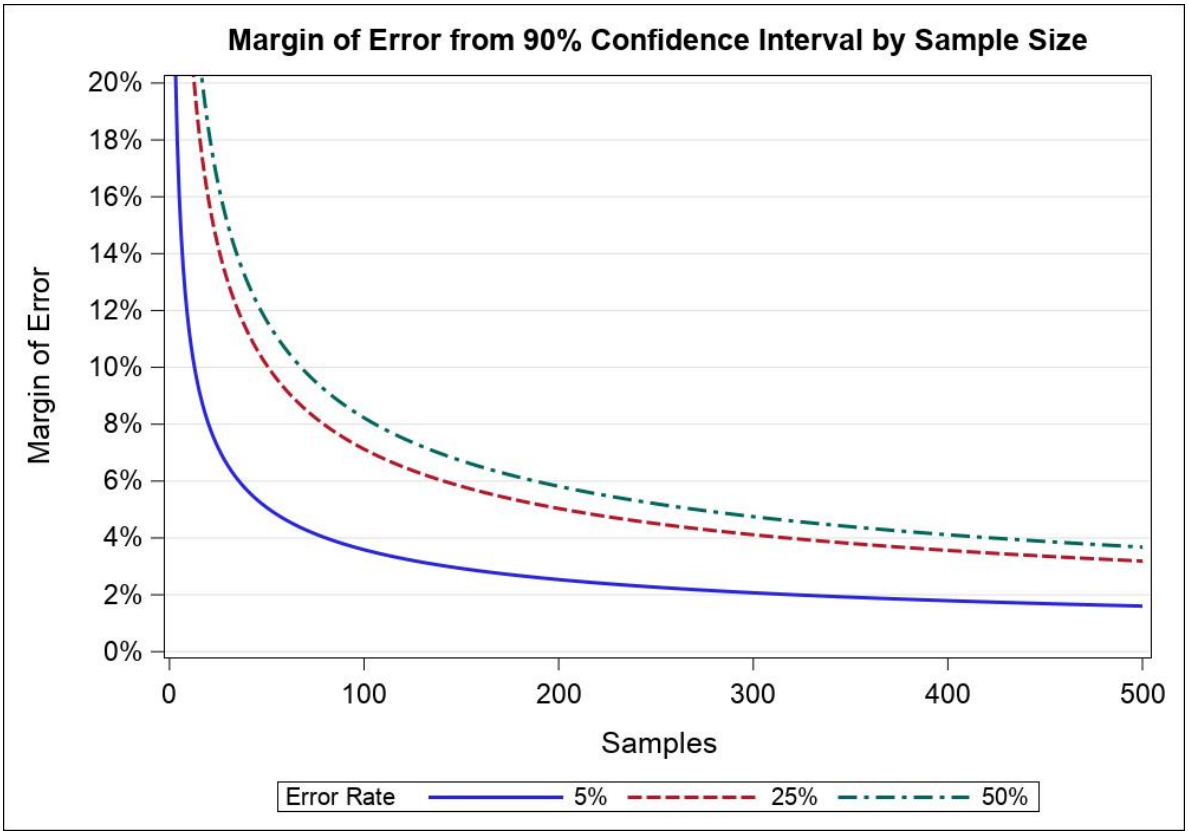

Figure C.1. *The effect of progressively larger sample sizes on the margin of error.*
Source: VA OIG statistician's analysis.

Table C.2 presents estimates derived from the sample population, including the sample results, estimate of claims or value, margin of error, lower 90 percent value, and upper 90 percent value.

Table C.2. Statistical Projections
Signature Performance-Processed Non-VA Care Claims Errors

Results	Sample results	Estimate of claims or value	Margin of error	Lower 90%	Upper 90%
Non-VA Care Claims–Total Claims with Actions by Signature Performance Employees (In Scope)	252	10,278,980	1,597	10,277,382	10,280,577
Non-VA Care Claims–Distribution Actions by Signature Performance Employees	245	9,768,627 (95%)	346,018 (3%)	9,422,609 (92%)	10,114,645 (98%)
Non-VA Care Claims–Rendering Decisions by Signature Performance Employees	87	5,534,060 (56%)	507,657 (5%)	5,026,403 (51%)	6,041,718 (61%)
Claims Not Accurately Processed by Signature Performance Employees	58	1,666,962 (16%)	464,229 (5%)	1,202,733 (12%)	2,131,192 (21%)
Non-VA Care Claims–Signature Performance Overall Distribution Issues	42	1,017,025 (10%)	341,752 (4%)	675,272 (7%)	1,358,777 (14%)
Non-VA Care Claims–Signature Performance Overall Claim Decision Issues	18	716,871 (13%)	330,439 (6%)	386,432 (7%)	1,047,311 (19%)

Results	Sample results	Estimate of claims or value	Margin of error	Lower 90%	Upper 90%
Non-VA Care Claims–Signature Performance Overall Claim Decision Nonissues	69	4,817,189 (87%)	330,439 (6%)	4,486,750 (81%)	5,147,629 (93%)
Non-VA Care Claims–Cost of Signature Performance Rendering Decision Issues	18	$3,627,368	$1,186,788	$2,440,581	$4,814,156

Source: VA OIG analysis of statistically sampled results projected over the sample population. Data used for analysis and projections were obtained from VA's Corporate Data Warehouse.

Appendix D: Management Comments

Department of Veterans Affairs Memorandum

Date: December 23, 2020

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

Subj: OIG Draft Report, Veterans Health Administration: The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor (VIEWS 03957887)

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

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report, The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor.

2. The Department of Veterans Affairs (VA) is committed to processing provider claims accurately and quickly, adopting similar technology used in the private sector to expedite claims processing. Nearly 19.9 million claims were adjudicated by VA between June 6, 2019 and September 11, 2020 (post-MISSION Act).

3. VA's new claims processing system, Electronic Claims Administration and Management System (eCAMS), fundamentally changed how claims are processed and does not require as much manual intervention as previous processing systems. VA instituted eCAMS after OIG's review. Therefore, the OIG couldn't include descriptions of the new claims processing system in its draft report. Issues described in the draft report around distribution sorting and manual adjudication are based on the old system. That system was less automated which meant there were more opportunities of unintentional human error. The new eCAMS eliminates many of the issues OIG described, including those around distribution sorting.

4. The Veterans Health Administration (VHA) optimizes claims processing speed and accuracy by supplementing its permanent workforce with contractors as claims volumes fluctuate. Since 2014, VHA has awarded contracts to assist with processing non-VA care claims. VHA will continue to make staffing decisions and use contractors to clear claims backlogs, which are primarily due to an increase in the volume of incoming claims.

5. VHA finds that the contractor followed guidance provided by local sites as required by the contract and cannot be faulted for inconsistencies between site specific guidance and Office of Community Care guidance, which may have resulted in variations in processing. The contract Performance Work Statement established that for Non-VA Care Claims: "Each system is unique to each individual facility and Consolidated Payment Centers; site specific guidance will be provided to the contractor." The contractor maintained Veterans Integrated Service Network (VISN) specific guidance based on intake and collaboration calls. In many cases VISN and local facility specific information allowed the contractor to meet the needs of its customer, the VA, by tailoring actions without deviating from the standard. An example would be a unique Provider contract, special handling, or nuances that do not affect the outcome of the claim processed. During OIG's audit, VHA created a master Guidebook to optimize the ability for contractors to consistently apply Office of Community Care's claims processing procedures.

6. I concur with recommendations 1, 2, 4 and 5 and concur in principle with recommendations 3 and 6. VHA considers recommendations 2, 3, and 6 fully implemented and asks OIG to consider closing them.

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: The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor

Date of Draft Report: October 23, 2020

Recommendations/Actions	Completion Date
Status	

The OIG recommended the Under Secretary for Health ensures:

Recommendation 1. The Payment Operations and Management directorate reevaluates all sample claims identified in this audit as not processed in accordance with Office of Community Care guidance, and takes appropriate corrective action as needed.

VHA Comments: Concur.

VHA's Office of Community Care (OCC) recognizes the importance of claims payment and processing accuracy. OCC will review the audit sample, determine if there were processing errors and take appropriate corrective action. To demonstrate completion of this recommendation, OCC will provide documentation of the review and action taken.

Status: In progress **Target Completion Date:** February 2021

Recommendation 2. There is a contract requirement that the contractor's employees must follow Office of Community Care guidance for processing non-VA care claims.

VHA Comments: Concur.

The Office of Community Care (OCC) will ensure the contractor is following OCC's guidance for processing claims. The Payment Operations and Management (POM) office developed a processing Guidebook that contains all guidance in one document. This allows for consistent application of procedures by the contractor and VHA employees.

The current contract directs the contractor to utilize OCC standard operating procedures (SOP) for processing claims. The Performance Work Statement of the contract states that the contractor will use procedure guides provided by OCC. In the Tasks section, the contract reiterates that SOP and other guidance will be provided by OCC to the contractor.

To demonstrate completion of this recommendation, OCC will provide the following documentation: The portion of the contract that addresses OCC guidance and SOPs; and the link to the POM Guidebook. VHA considers this recommendation fully implemented and ask OIG to consider closing it.

Status: Complete **Completion Date:** November 2020

Recommendation 3. The contractor's standard operating procedures for claims processing are accurate and a mechanism is put in place to keep the contractor's procedures updated to reflect current Office of Community Care claims processing procedures.

VHA Comments: Concur in principle.

The Office of Community Care (OCC) agrees the contractor should have accurate standard operating procedures (SOP) for claims processing. As specified in the contract, the contractor uses guidance provided by OCC. At the time of this review, the contractor had SOPs; however, VHA has transitioned to

a new claims processing system, Electronic Claims Administration and Management System (eCAMS). eCAMS processing is more automated with staff resolving edits and processing by exception. OCC developed a processing Guidebook that optimizes the ability for contractors to apply OCC's claims processing procedures.

OCC has established an eCAMS Business Oversight Committee designed to evaluate effectiveness of business processes associated with eCAMS as well as to review and identify enhancements to the adjudication system. Contract staff are active members of the committee. As improvements are identified, this committee is responsible for ensuring the Guidebook is maintained and revisions are shared with Payment Operations and Management leadership as well as contract support.

To demonstrate completion of this recommendation, OCC will provide the following documentation: The Guidebook showing one set of enterprise level guidance for claims processing; and the Charter for the eCAMS Business Oversight Committee. VHA considers this recommendation fully implemented and asks OIG to consider closing it.

Status: Complete **Completion Date:** November 2020

Recommendation 4. The Office of Community Care develops and implements clear controls for reviewing and updating, if necessary, the quality assurance surveillance plan requirements at least annually.

VHA Comments: Concur.

The Office of Community Care (OCC) concurs with reviewing and updating the quality assurance surveillance plan (QASP). The current QASP is pending updates to remove functions specific to the Fee Basis Claims System as the system sunsets and modifies the measures for claims processing in eCAMS. An annual meeting has been established with OCC, the Contracting Officer's Representative and contract managers to review the QASP. Verbiage will be added to the QASP documenting the yearly review date. To demonstrate completion of this recommendation, OCC will provide a copy of the updated QASP.

Status: In process **Target Completion Date:** February 2021

Recommendation 5. Payment Operations and Management personnel make full use of the established communication tracking tool.

VHA Comments: Concur.

The communication tracking tool continues to be used by the Office of Community Care (OCC). This ensures full visibility to potential claims issues and fosters communication between staff and managers. However, to ensure continuous improvement, OCC will issue additional guidance to staff on the usage and requirement of the communication tool. In addition, VHA will communicate with leadership on an ongoing basis to confirm usage. To demonstrate completion of this recommendation, OCC will provide the guidance provided to staff on usage of the communication tool.

Status: In process **Target Completion Date:** December 2020

Recommendation 6. Payment Operations and Management leaders provide timely training and additional guidance to its staff and the contractor's employees on applying and using standardized denial and rejection reasons, and employees follow procedures to process claims with no authorizations to ensure consistent and accurate claims processing.

VHA Comments: Concur in principle.

The OIG report references Fee Basis Claims System (FBCS) options that allowed staff to use different denial and rejection reasons for claims with fundamentally the same attributes. The Office of Community Care (OCC) has transitioned to the Electronic Claims Administration and Management System (eCAMs) for claims processing. eCAMS fundamentally changed how claims are processed and how standardization is controlled. Local sites do not have the ability to make any adjustments to the denial reasons, therefore usage of a non-standard reason is no longer applicable. eCAMS does not require the step by step manual intervention FBCS required. Staff no longer process claims by paying, rejecting or denying. eCAMS is an auto-adjudication system in which a series of validation checks and business rules are applied and if passed, then eCAMS will auto-adjudicate the claim. In eCAMS, staff resolve edits when claims fail to auto-adjudicate. If a validation check fails, an edit will present, and staff will research the edit and apply the appropriate action to resolve the edit.

The OCC Guidebook contains information specific to Authorization Edit Codes. If an authorization edit is presented, the staff can find the edit code in the Guidebook, which will provide detailed actions on how to review the claim to ensure consistent and accurate claims processing. To demonstrate completion of this recommendation, OCC will provide the Guidebook, which includes a chapter specific to Authorization Edit Codes. VHA considers this recommendation fully implemented and asks OIG to consider closure.

Status: Complete **Completion Date:** November 2020

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

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