US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

OFFICE OF ACQUISITION, LOGISTICS, AND CONSTRUCTION

Independent Audit Report of a Dialysis Provider's Contract Pricing and Billing Compliance

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September 19, 2024

MEMORANDUM

TO:	Contracting Officers Office of Acquisition, Logistics, and Construction
FROM:	Larry Reinkemeyer, Assistant Inspector General VA Office of Inspector General's Office of Audits and Evaluations (52)
SUBJECT:	Independent Audit Report of a Dialysis Provider's Contract Pricing and Billing Compliance

To meet the healthcare needs of eligible beneficiaries, VA contracts with community providers to provide dialysis care to veterans. In October 2013, VA awarded a contract to a dialysis provider to provide nationwide dialysis services to veterans. This contract, hereafter referred to as the old contract, expired in March 2019. The day after the old contract ended, the contractor was awarded another contract, hereafter referred to as the new contract.[1] Should all option periods be exercised with this new contract, it will expire in September 2024.

Dialysis filters fluids and wastes from the bloodstream. For individuals with end-stage renal disease, the procedure is lifesaving.[2] The contractor provided dialysis services for eligible beneficiaries as authorized by local VA facilities. The contractor must comply with Centers for Medicare & Medicaid Services (CMS) billing requirements under the end-stage renal disease Prospective Payment System to accurately price dialysis procedures when submitting claims for payment.[3]

When a contract expires, the payment office—for this contract, the VA Financial Services Center (FSC)—has primary responsibility for collecting contract debts identified by contracting officers.[4] When the old contract expired, the contracting officer requested that the VA Office of Inspector General (OIG) assist in determining whether VA or the contractor owed anything to the other party and, if so, how much, so that the old contract could be closed out. A limited distribution report was provided to the contracting officer with the OIG's finding and

[1] In this report, *contractor* and *provider* are used interchangeably.

[2] "Dialysis" (web page), Cleveland Clinic, accessed August 1, 2023, https://my.clevelandclinic.org/health/treatments/14618-dialysis.

[3] Both VA contracts contain this requirement. See CMS, "Outpatient [End-Stage Renal Disease] ESRD Hospital, Independent Facility, and Physician Supplier Claims," chap. 8 in *Medicare Claims Processing Manual*, August 6, 2021.

[4] FAR 32.602(a).

recommendation in August 2023.[5] During the course of the initial review, the OIG identified concerns in pricing accuracy and local billings. As a result, the OIG team conducted this additional attestation examination to determine whether the contractor complied with the billing terms and conditions of its contracts.

The OIG found that claim-pricing accuracy improved. Additionally, according to a contractor senior manager, incorrect billings to local VA facilities stopped; however, all refunds for these billings have not been completed.

Scope and Methodology

To determine pricing accuracy, the team reviewed claims data provided by the contractor and VA for the old and new contracts. The team selected a statistical sample of 88 claims from the old contract and 75 claims from the new contract and used CMS guidelines to price each sampled claim according to supporting documentation provided by the contractor.[6] To confirm refunds were completed in instances in which local VA facilities were incorrectly billed, the team judgmentally selected a sample of VA facilities and contacted them.

The team conducted the audit in accordance with generally accepted government auditing standards for attestation engagements and assertion-based attestation standards established by the American Institute of Certified Public Accountants.[7] As required by attestation standards, the team planned and performed procedures to provide reasonable assurance that the contractor's assertion that it complied with the contracts' terms and conditions is fairly stated in all material respects. Appendix A describes audit standards in greater detail, and appendix B provides additional detail on the examination's statistical sampling methodology.

Results and Recommendations

In the OIG team's opinion, except for instances of incorrect billings to local VA facilities as described below, the contractor's assertion that it billed in accordance with the terms and conditions of its old and new contracts is fairly stated in all material respects.

[5] The OIG restricted distribution of this report to the contracting officer and other designated recipients. This report contains contractor information that may be company confidential. Title 18 U.S.C. § 1905 provides specific penalties for the unauthorized disclosure of company confidential information.

[6] Claims from both VA contracts were included in this sample.

[7] The standards identify three types of attestation engagements: examinations, reviews, and agreed-upon procedures engagements. This report is based on the results of an examination—a type of audit referred to as simply an "audit" in this report. This audit included conducting tests and other auditing procedures necessary to accomplish the objectives. The team's responsibility is to express an opinion on the contractor's assertion that it complied with the terms and conditions of its VA contracts for billing based on the audit. The OIG team asserts that its examination provides a reasonable basis for the team's qualified opinion.

The OIG found that fewer pricing errors were present in the new contract than the old and that the contracts had no significant changes in claim-pricing contract language. The OIG also found that despite the FSC being the authorized processor of claims, the contractor billed local VA facilities. A contractor senior manager provided evidence that the contractor incorrectly billed 1,212 claims to local VA facilities and received almost $6.4 million from these facilities. For some of these claims, the contractor billed both the FSC and a local VA facility, thereby receiving payments from both for the same claim. The senior manager told the team that when an authorization was not timely or expected to be received for a claim under the national contract, the contractor sometimes billed a local VA facility. The official stated that local billings have stopped and that if a claim with a local VA address is loaded into the system in error, an internal report will identify the claim, and the contractor will stop the billing process.[8]

The contractor's official also indicated that the provider has begun refunding local VA facilities. The OIG contacted eight VA facilities to determine whether the facilities could identify these refunds. These eight VA facilities were chosen because they either had the highest amounts of paid local VA claims or the largest amounts of refunds from the contractor that had not yet been accepted by VA as of September 2023. One facility, the Dayton VA Medical Center in Ohio, confirmed that the contractor had refunded all payments as of December 2023. Officials from two of the facilities responded to the OIG that they could not find all the refunds.[9] Officials from the remaining five facilities provided various responses, such as saying local facilities did not have access to payment information and that refunds could not be identified in the system.[10]

In response to these results, the OIG recommends that the contracting officers request the contractor perform a self-audit of local VA claims and verify that the contractor has completed the process of refunding these claims.

Management Comments and OIG Response

The principal executive director and chief acquisition officer at the Office of Acquisition, Logistics, and Construction concurred with the OIG's findings and recommendations and provided responsive action plans to address them. The OIG will monitor VA's progress and follow up on the implementation of the recommendations until all proposed actions are completed. VA management comments are presented in full in appendix C.

[8] The team did not verify this control or whether billing of local VA facilities has stopped because that was outside the scope of the audit.

[9] These VA facilities are in Boise, Idaho, and San Antonio, Texas.

[10] These VA facilities are in Birmingham, Alabama; Fort Harrison, Montana; Miami, Florida; Orlando, Florida; and Richmond, Virginia.

The OIG presented its results to the contractor and obtained their views on the findings and conclusions during an oral discussion. The contractor requested that the OIG revise the text of the report for clarity and provided additional documentation for consideration. After review of the evidence, the team clarified the discussion of pricing errors and revised the findings' conclusions.

LARRY M. REINKEMEYER
Assistant Inspector General
for Audits and Evaluations

Contents

Abbreviations

CMS	Centers for Medicare & Medicaid Services
FSC	Financial Services Center
IVC	Office of Integrated Veteran Care
OCC	Office of Community Care
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

Following the March 2019 expiration of a contract with a dialysis service provider, a VA contracting officer asked the VA Office of Inspector General (OIG) to assist in determining whether VA or the dialysis provider owed anything to the other party and, if so, the amount, so that the expired contract could be closed. Over the entire 5.5-year period of the contract, VA paid nearly $1.3 billion for claims. VA awarded a new contract to the dialysis provider the day after the old contract expired. While performing the requested audit, the OIG identified concerns in pricing accuracy and billings to local VA facilities.

To address these concerns, the audit team conducted this assertion-based attestation examination, which involves performing procedures to obtain evidence about the contractor's assertion that it complied with the billing terms and conditions of its contracts. The nature, timing, and extent of the procedures selected depend on the auditor's judgment, including an assessment of the risks of material misstatement of the assertion, whether due to fraud or error.[11]

Objectives and Responsibilities

The VA OIG's objectives were to determine whether the contractor accurately priced dialysis procedures according to its contracts with VA when it submitted claims for payment to the VA Financial Services Center (FSC). The OIG team also reviewed the status of billings to local VA facilities.

The contractor's officials are responsible for ensuring that claims billed and paid under the old contract and the new contract complied with the contracts' terms and conditions, performance work statements, as well as Centers for Medicare & Medicaid Services (CMS) Medicare billing requirements.[12] The contractor's officials asserted that the contractor billed VA in accordance with the terms and conditions of its contracts. The contractor's officials are responsible for designing, implementing, and maintaining internal controls to prevent, or detect and correct, misstatement of claims due to fraud or error.

The OIG team is responsible for conducting an examination in accordance with generally accepted government auditing standards for attestation engagements and assertion-based attestation engagements, as well as with attestation standards established by the American

[11] See appendix A for more information about the audit standards.

[12] CMS, "Outpatient [End-Stage Renal Disease] ESRD Hospital, Independent Facility, and Physician Supplier Claims," chap. 8 in *Medicare Claims Processing Manual*, August 6, 2021.

Institute of Certified Public Accountants, and for expressing an opinion on the contractor's assertion that it billed according to the terms and conditions of its contracts.[13]

Background

The contractor is a nationwide provider of dialysis services.[14] When the provider's old contract with VA expired in March 2019, VA and the contractor spent over two years trying to reconcile the final amount paid under the contract. Because VA and the contractor were unable to come to an agreement, the contracting officer asked the OIG to assist in determining whether, on a net basis, VA or the contractor owed the other party money and, if so, how much.[15] A limited distribution report was provided to the contracting officer with the OIG's finding and recommendation in August 2023.[16]

VA Offices Responsible for Dialysis Services

To meet the healthcare needs of eligible beneficiaries, VA awarded contracts to provide dialysis care to veterans. Several VA offices are responsible for oversight of the nationwide dialysis services contracts:

- **VA National Acquisition Center.** The National Acquisition Center is a self-sustaining, revenue-generating organization for VA's Supply Fund. It is responsible for the establishment and administration of various national healthcare-related acquisition and logistics programs. One of its subsidiaries, the VA Denver Logistics Center, awarded and administered the old nationwide dialysis services contracts. The Denver Logistics Center also manages contract closeout activities for these contracts.
- **VA Strategic Acquisition Center.** The Strategic Acquisition Center provides contracting support to the Veterans Health Administration (VHA) through strategic sourcing and acquisition solutions for the provision of benefits and medical care for veterans. The new

[13] The standards identify three types of attestation engagements: examinations, reviews, and agreed-upon procedures engagements. This report is based on the results of an examination—a type of audit referred to as simply an "audit" in this report. This audit included conducting tests and other auditing procedures necessary to accomplish the objectives. The team's responsibility is to express an opinion on the contractor's assertion that it complied with the terms and conditions of its VA contracts for billing based on the audit. The OIG team asserts that its examination provides a reasonable basis for the team's qualified opinion.

[14] Dialysis is a lifesaving medical procedure that removes excess fluids and wastes from the bloodstream to treat end-stage renal disease. In this report, *contractor* and *provider* are used interchangeably.

[15] Per FAR 32.602(a), the payment office (in this case, the FSC) has primary responsibility for collecting contract debts identified by contracting officers.

[16] The OIG restricted distribution of this report to the contracting officer and other designated recipients. This report contains contractor information that may be company confidential. Title 18 U.S.C. § 1905 provides specific penalties for the unauthorized disclosure of company confidential information.

contract was awarded by the National Acquisition Center and was transferred to the Strategic Acquisition Center on October 1, 2019.

- **VHA Office of Community Care (OCC).** OCC was responsible for supporting patient care and providing executive program support to the under secretary for health. According to the contracting officer, the program office and contracting officer's representative for this contract were part of OCC. The contracting officer's representative was responsible for the technical administration of both contracts and ensured proper government surveillance of the contractor's performance.[17] For example, the contracting officer's representative was responsible for maintaining communication with the contractor, verifying that the contractor followed the terms and conditions of its contract, and auditing the contractor's performance.
- **VHA Office of Integrated Veteran Care (IVC).** In 2022, OCC and the Office of Veterans Access to Care joined together to form IVC to streamline integrated care access for veterans.[18] IVC is the current program office for the nationwide dialysis services contracts. The contracting officer's representative for the provider's new contract performs similar functions to the OCC contracting officer's representative described above.
- **VA Financial Services Center.** The FSC provides claims processing for the nationwide dialysis services contracts under a service-level agreement with IVC. The FSC is solely responsible for adjudicating, processing, and paying claims to contracted dialysis providers.[19]

Billing and Pricing Dialysis Claims under the VA Contracts

In October 2013, VA awarded the provider a contract for nationwide dialysis services. This old contract consisted of a base period and four one-year option periods and was completed in March 2019.[20] In April 2019, VA awarded the provider a new contract not to exceed $3 billion, which consisted of a base period, four one-year option periods, and two six-month option periods. The new contract is scheduled to expire in September 2024.[21]

[17] The contracting officer's representative was part of OCC for the old and new contracts. The contracting officer's representative changed from OCC to the Office of Integrated Veteran Care (IVC) in May 2022.

[18] "IVC Alliance (May 2022): Welcome to the Office of Integrated Veteran Care (IVC)" (web page), VHA, accessed August 1, 2023, https://content.govdelivery.com/accounts/USVHA/bulletins/318f231.

[19] VA Service-Level Agreement, "Dialysis Claims Processing," October 1, 2020.

[20] Hereafter, this contract is referred to as the old VA contract.

[21] Hereafter, this contract is referred to as the new VA contract.

According to the contracting officer, the nationwide dialysis services contracts are billed using claims.[22] When local VA staff determine that a veteran is eligible to receive dialysis care at a non-VA facility, VA staff create an authorization for the veteran, which is required for every claim.[23] The veteran then receives treatment at one of the contractor's centers, or treatment is coordinated through the facility and delivered in the veteran's home.

Once care has been provided, the contractor submits dialysis claims to the FSC monthly after compiling all necessary information for each claim, such as patient records, the starting date of dialysis treatment, and billing information from its internal systems.[24] After receiving a claim, the FSC independently calculates the price of the claim to determine the contractual price that should be paid and either sends payment or denies the claim.[25] An FSC dialysis claims team coordinator noted the FSC does not rely on the billed charges that are included on the claim. A contractor senior manager explained that if the contractor disagrees with the amount paid or a claim denial, it either submits a revised claim or contacts FSC officials to discuss the claim.

All claims under the contracts are submitted and paid using CMS guidelines and pricing methodology. The contractor is required to comply with CMS billing requirements under the end-stage renal disease Prospective Payment System.[26] Drugs, laboratory services, supplies, and facility-related costs are bundled into the price rather than billed separately. A claim typically consists of multiple billed procedures for one veteran for up to one month. VA pays the contractor the full CMS allowable amount under the Prospective Payment System multiplied by a negotiated contract rate. Figure 1 shows how the contractor and VA should price a dialysis claim using adjustments such as those for a low-volume provider, which is a facility-level adjustment that increases the price of a claim.

[22] A claim, which functions as an invoice, contains billings for one month of dialysis services for one veteran. Claims are submitted using the UB-04 form, which is a uniform institutional provider bill suitable for use in billing multiple third-party payors.

[23] This requirement is included in both VA contracts.

[24] The starting date, which is also known as the onset date, is found on CMS Form 2728. This form is completed when a patient first begins end-stage renal disease treatment. For this audit, the team used this form to determine the date that regular chronic dialysis treatment for end-stage renal disease began.

[25] VA Financial Services Center Non-VA Contracted Dialysis, "Claims Processing" (standard operating procedure), updated October 2021. The team focused on and used VA payments because the FSC independently determined prices. Thus, in this report, the team refers to VA prices based on the analysis of VA payments.

[26] This requirement is included in both VA contracts.

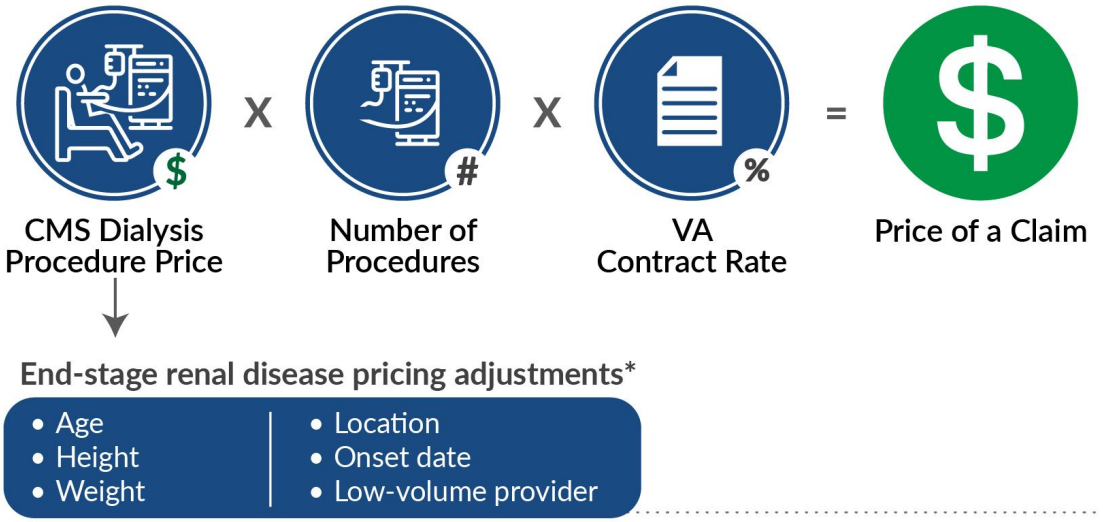

Figure 1. *Pricing a VA dialysis claim.*
Source: VA OIG review of FSC letters to the contractor and Medicare policy manuals.
** This list is not comprehensive; pricing adjustments not listed also occur.*

Criteria

To gain an understanding of the requirements of VA dialysis billing, the team reviewed the following criteria:

- The contractor's old and new VA contracts, including each base contract and subsequent modifications
- Federal Acquisition Regulation Part 52.212-4 (i)(5)
- *Medicare Benefit Policy Manual*, Chapter 11, "End Stage Renal Disease" (revised March 1, 2019)
- *Medicare Claims Processing Manual*, Chapter 8, "Outpatient [End-Stage Renal Disease] ESRD Hospital, Independent Facility, and Physician Supplier Claims" (revised August 6, 2021)
- *Medicare Claims Processing Manual*, Chapter 25, "Completing and Processing the Form CMS-1450 Data Set" (revised August 6, 2021)
- VHA Handbook 1042.01, *Criteria and Standards for VA Dialysis Programs* (updated May 23, 2016)
- VA Financial Services Center Claims Processing, Standard Operating Procedure, "Non-VA Contracted Dialysis" (updated October 2021)
- The contractor's revenue operations policies and procedures

What the OIG Did

The audit team performed this examination from July 2023 through June 2024. The universe of claims in this audit included 355,540 claim groups from the old contract and 81,012 claim groups from the new contract.[27] The old contract claims covered dialysis services provided between October 2013 and March 2019, while the new contract claims covered October 2021 to September 2022. The team excluded some claims from each universe, such as claims that VA and contractor's officials agreed were paid correctly. See appendix B for more information on statistical sampling.

To address the examination objectives, the audit team reviewed criteria and claims data for both of the provider's contracts. They also corresponded and met with contractor and VA officials. To assess pricing accuracy, the team priced sample claims, relying on supporting documentation supplied by the contractor. Finally, the team sought confirmation of refunds from a select sample of claims that had been billed to local VA facilities. For more details regarding the audit's scope and methodology, see appendix A.

[27] A claim group may have more than one claim associated with a veteran. In this report, *claim* is used interchangeably with *claim group*.

Results and Recommendations

The evidence obtained is sufficient and appropriate to provide a reasonable basis for the team's qualified opinion. In the OIG team's opinion, except for the effects of the incorrect billings to local VA facilities giving rise to the modification described in finding 2, the contractor's assertion that it billed in accordance with the terms and conditions of its old and new contracts is fairly stated in all material respects as of the team's fieldwork completion date. However, subsequent events may disclose relevant information not now discernible.

Finding 1: Contractor Has Improved Claim-Pricing Accuracy

The OIG found that the contractor made fewer pricing errors under the new contract than the old contract. Specifically, the OIG team determined the contractor incorrectly priced 47 of 88 sampled claims under the old contract while incorrectly pricing two of 75 sampled claims under the new contract. Projecting the results of the sampled claims, the OIG estimated that the contractor incorrectly priced approximately 32 percent of claims that it submitted to VA for payment under the old contract, but, at most, 7 percent of claims were incorrectly priced under the new contract for fiscal year 2022.

The contractor's pricing errors included both underpriced and overpriced claims.[28] Table 1 shows the pricing accuracy of sampled claims.

Table 1. Pricing Accuracy of Sampled Claims

Claim status	Old contract		New contract	
Incorrectly priced claims	Underpriced	22	Underpriced	1
	Overpriced	25	Overpriced	1
Total incorrectly priced claims		**47**		**2**
Correctly priced claims		41		73
Total		**88**		**75**

Source: VA OIG analysis of VA claims from both contracts.

Both contracts require the provider to follow CMS end-stage renal disease billing guidelines for claim pricing. The OIG team identified some differences in wording between the old and the new contracts but did not find any significant changes that affected claim pricing.

[28] Dollar amounts of the underpriced and overpriced claims were provided to the contracting officer in the prior limited distribution report to assist in closing out the old contract.

Pricing Errors Improved between Old and New Contracts

The OIG team identified 49 claims with pricing errors or discrepancies in the 163 sampled claims examined—of these 49 claims, 47 were under the old contract.[29] Errors included wrong starting dates and one discrepancy with an incorrectly applied low-volume provider adjustment. For instance, the team found that one claim in October 2014 was potentially overpriced by the contractor because it included the low-volume provider adjustment. VA pricing officials did not use the low-volume provider adjustment to calculate the price of the claim. The team calculated that the claim was overpriced by $98.94.

Although pricing accuracy did improve from the old contract to the new, another example of a claim that the provider mispriced was from the new contract. The contractor overpriced the claim because they used the wrong starting date.[30] A contractor senior manager confirmed that the date that the veteran began treatment at the provider's facility was used as the starting date instead of the date that the veteran began chronic dialysis treatment.[31] The team noted that VA determined a similar price for this claim (a difference of 13 cents). However, according to the contract, which includes CMS end-stage renal disease guidelines in its pricing, the payment should have been less. Figure 2 shows the price that the FSC calculated for this claim, the contract price, and the excess amount that was paid.

Figure 2. *Mispriced claim example.*
Source: VA OIG review of supporting claim documentation.

The team noted VA's calculated prices, which were the result of the FSC independent pricing process, matched the contractor's for 49 of 62 claims under the new contract; in comparison,

[29] The audit team made changes to this section of the report based on additional evidence provided by the contractor after fieldwork was completed.

[30] CMS allows for a higher reimbursement rate for dialysis procedures during the first 120 days after a patient begins chronic treatment for end-stage renal disease.

[31] A patient with chronic kidney disease can progress to end-stage kidney failure, which is fatal without dialysis or a kidney transplant. In contrast, temporary hemodialysis helps remove toxins and excess fluids from the body while the kidneys heal. CMS defines the starting date as the first date when regular chronic (or maintenance) dialysis began.

one of 48 claims matched under the old contract.[32] A VHA audit report had a similar finding in that nearly 61 percent of dialysis claims processed by the FSC in fiscal year 2015 under the old contract had pricing errors, and a later audit reported that the overall payment accuracy rate improved.[33]

According to a contractor senior manager, prior to the old contract, the national dialysis services contracts were priced using rates negotiated with VA, rather than CMS rates. The change required the provider to update its pricing methodology. The significant decrease in the number of errors between the old and new contracts indicates contractor pricing errors may have been resolved.

Because the OIG found that the contractor's pricing had fewer errors and was more in agreement with VA's pricing under the new contract than the old contract, the OIG does not have any recommendations for this finding.

Finding 1 Conclusion

The contractor provided dialysis services for veterans, which is a lifesaving medical procedure. Both contracts were to be billed in accordance with CMS guidelines at an agreed-upon rate. For the old contract, which is in the process of being closed out, VA paid the contractor almost $1.3 billion. Although the OIG found the contractor had significant pricing errors or discrepancies under the old contract, the OIG determined pricing accuracy improved during the new contract based on the year of claims activity examined. In addition, pricing between the contractor and VA appears to be more in agreement for the new contract; thus, the OIG is not providing recommendations for this finding.[34]

[32] The team excluded 13 claims from the new contract and 40 claims from the old contract because either the claims had no recorded VA payment or the team could not match the contractor's claim to a corresponding VA claim. This resulted in 62 claims from the new contract and 48 claims from the old, for a total of 110 claims reviewed that the team was able to match to VA data.

[33] VHA, *FY 2015 Nationwide Dialysis Contracts (DNC) Program Audit*, July 8, 2015; VHA, *Nationwide Dialysis Services Contract Follow-Up Audit Report*, September 22, 2021. These internal reports are not publicly accessible.

[34] The audit team made changes to the findings' conclusions based on evidence provided by the contractor after fieldwork was completed.

Finding 2: Contractor Incorrectly Billed Local VA Facilities $6.4 Million

During the prior audit, the OIG found that under both contracts, the contractor incorrectly billed local VA facilities when only the FSC should have been billed under the national contracts.[35] The OIG team identified unusual payments and brought them to the attention of the provider's officials. A contractor team researched the billings and found the contractor billed local VA facilities for 1,212 claims, receiving almost $6.4 million from those facilities.

FSC officials and the contracting officers stated that they were not aware that the contractor was billing local VA facilities. A contractor senior manager told the OIG team that when an authorization was not timely or expected to be received for a claim under the national contract, the provider sometimes billed a local VA facility. The manager provided evidence that the contractor began refunding VA for these payments in June 2022.

All Claims Should Be Processed by the FSC

Both of the provider's VA contracts state that all claims will be processed by the FSC and that claims will include payor identification for the FSC. However, the contractor sometimes billed both a local VA facility and the FSC. A contractor senior manager explained that when an authorization under the national contract was not obtained, contractor officials understood those claims were not covered under the national contract; therefore, the provider billed the local VA facility. The manager also mentioned timeliness or delays in receipt of an authorization. Contractor officials further noted the payor (in this case, VA) will be billed even without an authorization, since service was provided. In these instances, the contractor does not always expect to be reimbursed but will sometimes appeal a denial. The contractor senior manager acknowledged that there were no other contracts with local VA facilities for services provided at contractor dialysis centers.

On May 3, 2022, the audit team asked the contractor about unusually large payments received from VA for two claims that the team observed in the contractor's claims data. A contractor senior manager acknowledged that payment was received from both the FSC and a local VA facility for each claim. The manager explained that its billing system considered the FSC and local facilities as the same payor, so not all local billings were identified. The manager also noted that some payments made by local facilities in their system had not been reconciled.

According to a contractor senior manager, the contractor reconciles invoices and payments on a continual basis and sends the FSC a list of claims quarterly that need to be refunded or adjusted. The manager told the team that in 2016, the contracting officer asked the provider to wait to send a refund for an overpaid claim until a bill of collection was issued.[36] The contractor appeared to

[35] VA Service Level Agreement, "Dialysis Claims Processing," October 1, 2020.

[36] The contractor provided the team with documentation from the Denver Logistics Center with instructions to hold refunds until a bill of collection was issued.

overlook some of these local VA claims and never reconciled them until the OIG brought its attention to the issue.

Claims Were Inappropriately Billed under Old and New Contracts

As of March 22, 2024, a contractor senior manager had identified 900 claims under the old contract that were inappropriately billed to and paid by local VA facilities. The manager also asserted that 743 of these claims had been successfully refunded, which left 157 claims that still needed to be reimbursed. See table 2 for the status of local VA claims under the old contract that the provider identified.

Table 2. Local VA Claims under the Old Contract

Status of local VA claims	Number of claims	Amount*
Refunded	743	$3,596,860
Not refunded	157	$640,253
Total	**900**	**$4,237,113**

Source: VA OIG analysis of local VA claims from the old contract.
** Numbers are rounded.*

Contractor officials confirmed that the contractor continued to bill local VA facilities once the new contract began in April 2019 and that, as of March 22, 2024, it had also billed local facilities and been paid for 312 claims under the new contract. According to a contractor senior manager, 276 of these claims have been refunded to VA, and 36 claims have not. See table 3 for the status of local VA claims under the new contract according to the provider.

Table 3. Local VA Claims under the New Contract

Status of local VA claims	Number of claims	Amount*
Refunded	276	$1,987,437
Not refunded	36	$159,291
Total	**312**	**$2,146,728**

Source: VA OIG analysis of local VA claims from the new contract.
** Numbers are rounded.*

Contractor officials identified a total of 1,212 claims that should not have been billed to local VA facilities. However, the audit team could not verify that this represented all possible incorrect billings because that was outside the scope of the audit. The contracting officer should request that the provider perform a self-audit of the local VA claims to ensure they are all identified and refunded.

Contractor Billed Both the FSC and Local VA Facilities for Some Claims

Contractor officials initially claimed that the contractor did not double bill VA for services provided. However, the contractor was paid almost $2.4 million by the FSC and nearly $4.4 million by local VA facilities for the same claims.[37] Specifically, of the 1,212 local VA claims, 767 of those claims had payments from both the FSC and a local VA facility. Of the 767 claims, 520 were under the old contract. For example, contractor officials provided evidence that on February 1, 2019, the provider billed the Boise VA Medical Center for a claim, and the Boise facility paid $4,084.92 to the contractor. However, about six months later, the contractor also billed the FSC for the same claim, and the FSC paid $5,146.96. A contractor senior manager provided support that the contractor sent the Boise facility a refund on July 21, 2022, and a facility supervisory accountant confirmed that the refund was applied on November 29, 2022.

Contractor Asserted It Stopped Billing Local VA Facilities and Has Begun Making Refunds

Contractor officials stated that an operational change was made in October 2020 to stop billing local VA facilities. They identified 441 local VA claims billed in 2019, 22 claims in 2020, and three claims in 2021. A contractor senior manager provided data to the OIG team that showed that the most recent date a claim was submitted to a local VA facility was on March 23, 2021. The manager asserted a control was added to ensure no claims with a local VA facility billing address are loaded in the contractor's internal system. The manager also stated that a control is in place to catch any local VA claims that are loaded in error: a monthly report will run that will capture those claims and ensure they will not be billed.[38]

The contractor began refunding local VA facilities in June 2022. As of March 22, 2024, a contractor senior manager confirmed the provider has refunded nearly $5.6 million for local VA claims under both contracts.

Only One of Eight Local VA Facilities Was Able to Identify All Refunds, So Follow-Up Is Needed

The team contacted eight local VA facilities to validate the contractor's statements that it had successfully issued refunds.[39] These facilities were contacted because data indicated that they

[37] The contractor was paid a total of nearly $6.4 million from local VA facilities. Of that amount, $2 million was for claims that were not paid by the FSC.

[38] The team did not verify whether the control is in place and working or whether billing of local VA facilities has stopped because the contractor's internal controls are outside the scope of this audit.

[39] The VA facilities could not isolate all payments to the contractor; therefore, a scope limitation exists and the audit team relied on the contractor's statements regarding local VA payments. See appendix A for more information.

either sent the contractor a large amount of payments or had a large amount of unaccepted refunds from the contractor as of September 28, 2023.[40] Of the eight facilities contacted, one confirmed the contractor had refunded all payments as of December 2023.[41] Two of the other facilities' officials responded to the OIG team that they could not find all the refunds.[42] The team received various responses from the remaining five facilities, such as that local facilities did not have access to payment information and refunds could not be identified in the system.[43] Two of the eight facilities contacted are highlighted below.

Boise VA Medical Center

The contractor identified 44 claims from April 2015 to September 2019 that were incorrectly billed to the Boise facility. The provider received approximately $1.3 million for these claims from this facility and, as of September 28, 2023, a contractor senior manager affirmed all but two claims had been refunded. According to a facility supervisory accountant, the two claims that the contractor identified as not completely refunded were combined into one check that was later received on October 17, 2023. However, facility officials conducted a preliminary analysis and identified refunds for only 22 of the 44 claims, including the two claims identified as not completely refunded.[44] The facility supervisory accountant stated that additional time would be needed to research any refunds not initially found. Table 4 shows the refund status of the contractor's incorrect billings sent to the facility.

[40] The team judgmentally selected VA facilities in Birmingham, Alabama; Boise, Idaho; Dayton, Ohio; Fort Harrison, Montana; Miami, Florida; Orlando, Florida; Richmond, Virginia; and San Antonio, Texas.

[41] Dayton VA Medical Center in Ohio.

[42] These VA facilities are in Boise, Idaho, and San Antonio, Texas.

[43] These VA facilities are in Birmingham, Alabama; Fort Harrison, Montana; Miami, Florida; Orlando, Florida; and Richmond, Virginia.

[44] Boise facility officials also stated that there were three claims with authorization numbers that appeared to not be associated with this facility. The audit team was unable to confirm that those three claims, for which the contractor received over $235,000, were refunded to the correct facility.

Table 4. Status of Boise Facility Claims

Claim refund status	Number of claims	Dollar value of claims*
Refund found	22	$128,841
Refund not found	22	$1,172,446
Total claims	**44**	**$1,301,287**

Source: Contractor claims data and information provided by Boise facility officials.
** Numbers are rounded.*

Audie L. Murphy Memorial Veterans' Hospital

The audit team contacted officials at the Audie L. Murphy Memorial Veterans' Hospital in San Antonio, Texas, to discuss 36 claims that the contractor identified as incorrectly billed. The team was then referred to Veterans Integrated Service Network (VISN) 17 finance officials.[45] The contractor received almost $188,000 for these claims. A VISN 17 area manager confirmed that payments were made to the contractor for 33 of the 36 claims. However, they were only able to validate three of 36 refunds. The manager stated that many providers send unsolicited refunds, not just the contractor, and that often there is not enough identifying information included so that the amount can be applied to the proper account. They also noted that ideally, a provider will reach out to the VISN before sending a refund, so that the VISN can send a bill of collection to the provider before a refund is sent.

Since both VISN 17 and the Boise facility could not validate all refunds, additional follow-up should be conducted. It is in the best interest of taxpayers that the contracting officer verify that the contractor has completed the process of refunding all local VA facility claims.

Finding 2 Conclusion

The OIG identified unusual payments in the claims data, and the contractor acknowledged that it billed local VA facilities, sometimes in addition to the FSC. This resulted in double billings, of which neither the FSC nor the contracting officers were aware. Overall, the contractor incorrectly billed and was paid nearly $6.4 million. Local VA facilities were only able to confirm some of the refunds that the contractor claimed were made. Billing both the FSC and local facilities puts taxpayer dollars at risk. Therefore, the contracting officers should request that the contractor perform a self-audit and verify that it has completed the claims refund process.

[45] VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight.

Recommendations 1–2

The OIG made the following recommendations to the contracting officers:

1. Request that the contractor perform a self-audit of local VA claims.
2. Verify that the contractor has completed the process of refunding local VA claims.

Management Comments

The principal executive director and chief acquisition officer at the VA Office of Acquisition, Logistics, and Construction concurred with the OIG's findings and recommendations and provided responsive action plans to address the recommendations.

To address recommendation 1, the contracting officers will request that the contractor complete a self-audit for both contracts. For recommendation 2, officials at the National Acquisition Center and the Strategic Acquisition Center will recommend that IVC review and validate the OIG's recommendation and will work with IVC to complete the task of verifying local claim refunds. Appendix C contains the full text of VA's response.

The OIG presented its results to the contractor and obtained oral comments on the report's findings and conclusions. The contractor requested that the OIG revise the text of the report for clarity and submitted additional documentation for consideration.

OIG Response

The corrective action plans provided by the principal executive director and chief acquisition officer at the Office of Acquisition, Logistics, and Construction are responsive to the intent of both recommendations. The OIG will follow up on the implementation of the planned actions and will close the recommendations when sufficient documentation has been provided, illustrating that corrective actions have been implemented. To address the contractor's oral comments, the OIG revised the discussion of pricing errors and the findings' conclusions as noted in the text.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team performed this examination from July 2023 through June 2024. The team requested claims data for the old contract from the contractor and VA and received the data in April 2022; however, the contractor data required revision. A contractor director provided updated data in July 2022. Once the team identified a sample of claims, a contractor senior manager provided supporting documentation for each sampled claim in October and November 2022.

The team requested claims data for the new contract from the contractor and VA, which were received in August 2023. The team selected a sample of claims and the contractor provided additional claim documentation in September 2023. The old contract claims covered dialysis services provided between October 2013 and March 2019, while the new contract claims covered October 2021 to September 2022.[46]

The universe of claims in this audit included 355,540 claim groups from the old contract and 81,012 claim groups from the new contract.[47] The team excluded some claims from each universe, such as claims that VA and the contractor agreed were paid correctly or claims with zero expected payment from VA. See appendix B for more information on sampling techniques.

Table A.1 shows the size of the universe, sampled population, and sample for each contract.

[46] To accomplish the audit objectives, the team reviewed one year of claims from the new contract.

[47] A claim group has more than one line of data that is associated with a single combination of a veteran, a service start date, and a service end date. Generally, claim groups with multiple lines had more than one payment made by VA for the claim. In this report, *claim* is used interchangeably with *claim group*.

Table A.1. Size and Value of Universes, Sampled Populations, and Samples

Category	Old contract's number of claims and dollar value*	New contract's number of claims and dollar value*
Universe	355,540 $1,292,218,595	81,012 $309,766,335
Sampled population	228,111 $828,125,207	80,484 $309,533,911
Sample	88‡ $266,559	75 $280,149

Source: VA OIG analysis of claims from both contracts.
** Dollar values are rounded.*
‡ The sample from the old contract included 100 claims, but 10 claims were removed because they could have already been included in other sampled strata. Of the remaining 90 claims, one could not be priced and another was an incorrect claim for which the contractor expected no payment, so these claims were not included in the 88-claim sample used for projections.

Scope Limitations

Initially, the team attempted to obtain payment information directly from VA financial systems but could not identify all transactions between VA facilities and contractor treatment centers. Therefore, the audit team could only rely on data provided by both the Financial Services Center (FSC) and the contractor regarding payments, which resulted in a scope limitation. Because of this initial scope limitation, when the team reviewed local VA payments and refunds, they first relied on the contractor's statements. Then, the team contacted eight local VA facilities and received some preliminary confirmations but did not further research unconfirmed refunds because doing so was beyond the scope of this engagement. The focus of the audit was the provider's contract compliance.

Methodology

To address the examination objectives, the team performed the following activities:

- Examined criteria including both of the contractor's VA contracts and their modifications, the Medicare Benefit Policy Manual, and the Medicare Claims Processing Manual.
- Reviewed claims data provided by VA and the contractor for both contracts. The team used these data to select a sample of 88 claims from the old contract and 75 claims from the new contract. See appendix B for more information on sampling techniques.
- Conducted meetings and had correspondence with contractor and VA officials.

- Priced each sampled claim using supporting documentation provided by the contractor. These documents included claims forms submitted to VA, patient records, and correspondence between the contractor and VA. The team used Centers for Medicare & Medicaid Services pricing guidelines to calculate claims prices.[48]
- Selected eight local VA facilities and communicated with them regarding contractor refunds for claims from both contracts.

Internal Controls

The team obtained an understanding of internal controls over the contractor's pricing and billing processes relevant to the engagement. This understanding enabled the team to identify and assess the risks of material misstatement in the claims submitted to VA under these contracts; to provide a basis for designing and performing procedures to respond to the assessed risk; and to obtain reasonable assurance to support the team's opinion on the contractor's compliance with the terms and conditions of its contracts. However, the team did not design and perform tests of controls because the team did not intend to rely on internal controls and the subject matter of this OIG report is not internal controls. Accordingly, the team does not express an opinion on the contractor's internal control system.

Fraud and Noncompliance Assessment

In conjunction with understanding the assertion relating to the contractor's claims for this engagement, the team was alert to indicators of risk of material misstatement due to fraud and due to noncompliance with provisions of laws, regulations, and contracts. The team

- made inquiries of appropriate parties to determine whether they had knowledge of any actual, suspected, or alleged fraud or noncompliance with laws, regulations, and contracts affecting the contractor's claims data;
- evaluated whether there were unusual or unexpected relationships within the contractor's claims data and other related information that indicated risks of material misstatement due to fraud or noncompliance with laws, regulations, and contracts; and
- evaluated whether other information obtained indicated risk of material misstatement due to fraud or noncompliance with laws, regulations, and contracts.

[48] The audit team used version 21.2 of the CMS end-stage renal disease PC Pricer to price dialysis claims from the old contract and the CMS end-stage renal disease Web Pricer to price claims from the new contract.

The team did not identify any instances of fraud or potential fraud during this examination or any instances of noncompliance with laws, regulations, or contracts except for certain contract-related noncompliance issues discussed in the "Results and Recommendations" section of this report.

Data Reliability

The team relied on computer-processed data from the contractor and VA to conduct this examination. To assess the reliability of the data, the team interviewed knowledgeable officials from the contractor and VA and reviewed documentation about systems and processes. The team performed data reliability tests on contractor and VA claims data from both contracts. The team sought to determine whether any data were missing from key fields or were outside the time frame requested. The team also assessed whether the data contained obvious duplication of records, had alphabetic or numeric characters in incorrect fields, or had illogical relationships among data elements.

The team found the first set of the provider's old contract claims data to be inadequate to achieve the examination objectives. The team requested a revised dataset from the contractor that incorporated changes such as eliminating authorization numbers shared by veterans and adding missing social security numbers. The team also requested a second dataset from VA. For the second phase of the audit, the team requested new contract claims data from the contractor and VA and found these data to be adequate to achieve the examination objectives. The team concluded that the computer-processed data obtained from the contractor and VA were sufficiently reliable for the team's examination purposes.

Government and Professional Standards

The OIG conducted its examination in accordance with generally accepted government auditing standards for attestation engagements and assertion-based attestation standards established by the American Institute of Certified Public Accountants.[49] The standards require the OIG team to be independent and to meet the team's other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement. The standards require that the OIG team plan and perform the examination to obtain reasonable assurance about whether the contractor's assertion is fairly stated in all material respects. Accordingly, the OIG team's examination included conducting tests and other auditing procedures that the team considered necessary to accomplish the objectives. The audit team's responsibility is to express an opinion on the

[49] The standards identify three types of attestation engagements: examinations, reviews, and agreed-upon procedures engagements. This report is based on the results of an examination—a type of audit that this report simply refers to as an "audit." The audit included conducting tests and other auditing procedures that were necessary to accomplish the objectives. The team's responsibility is to express an opinion on the company's assertion based on the audit. The OIG team believes that its audit provides a reasonable basis for the team's qualified opinion.

contractor's assertion that it billed in accordance with its VA contracts. The OIG team believes that its examination provides a reasonable basis for the team's qualified opinion.

The team provided a summary of its examination results to the contractor and obtained comments. The contractor's views are incorporated in the report as appropriate. The team achieved the examination objectives and identified corrective action without developing the elements of a finding. Generally accepted government auditing standards 7.19 and 7.48 require the elements of a finding only to the extent necessary to achieve the examination objectives or to the extent necessary to assist oversight officials in understanding the need for taking corrective action.[50]

[50] GAO, *Government Auditing Standards*, 7.19, "Requirements: Findings," and 7.48, "Requirements: Presenting Findings in the Report," GAO-21-368G, April 2021.

Appendix B: Statistical Sampling Methodology

Approach

The audit team reviewed a statistical sample of dialysis claims from each contract. The team used statistical sampling and analysis to determine whether the contractor accurately priced dialysis claims when they were submitted to VA for payment.

Population

This appendix describes sampling and analysis for two separate, but related, populations—claims from the old contract and claims from the new contract.

Old VA Contract

The population for claims from the old contract was based on two files that contained claims data. The contractor provided one file, and VA provided the other. Data analysis for this project was complicated by the fact that the contractor and VA used different claim names in their files. Moreover, there were cases in which more than one line of data was associated with a single combination of a veteran, a service start date, and a service end date. In some of these cases, the lines corresponded to the same claim name, but in other cases, they were associated with different claim names. To simplify the data, the team grouped all lines with the same veteran, service start date, and service end date. These sets of lines were denoted as "claim groups."

The contractor and VA both provided data for 319,384 claim groups. However, the contractor provided data for an additional 33,428 claim groups that were not included in the VA data. Similarly, VA provided data for 2,728 claim groups that were not included in the contractor data. As such, there were 355,540 unique claim groups represented by the two data files.

To obtain the review population for this audit, the team excluded all claim groups that met any of the following criteria:

1. Claim groups with data from both entities, with both agreeing that the correct amount was paid
2. Claim groups with data from both entities, with both concurring on the amount that is still owed to the contractor (this amount could be positive or negative, if both agree that a refund is owed to VA)
3. Claim groups with data from both entities, with the contractor stating that the correct amount has been paid but with VA in disagreement (note that there were only 147 such claim groups)
4. Claim groups from contractor data only, with the provider stating that it neither expects nor has received reimbursement

5. Claim groups from contractor data only, with the provider stating that no additional reimbursement is owed

Based on these exclusions, the review population consisted of 228,111 claim groups: (1) 225,383 claim groups included in the contractor data only or in both the contractor data and the VA data and (2) 2,728 claim groups in the VA data only.

Whereas the size of the review population is known (228,111 claim groups), the size of the target population must be estimated based on a review of sampled claims. During its sample review, the team was able to match all sampled VA-only claim groups with contractor claim groups in the review population. That is, there were no cases in which there was truly no contractor data corresponding to VA data. Consequently, the team accepted the 225,383 claim groups included in the contractor data as the target population for this audit.

New VA Contract

The VA Office of Inspector General (OIG) team requested claims data from VA and the contractor for the new contract. The population used for projections was based on the contractor's file, which contained 81,012 claim groups. To obtain the review population for this audit, the team excluded claims that were voided by the contractor so that the resulting population consisted of 80,922 claims. The population was further reduced after the team noted that one of the claims should not have been included in the sample because it contained no billable dialysis procedures and the contractor's price for the claim was zero. Based on this information, no claims with a billed value of zero were truly eligible for sampling. In effect, the size of the sampling frame (and the estimated size of the target population) was therefore reduced to 80,484.

Sampling Design

Old VA Contract

The team selected a statistical sample of 100 old contract claims from the review population described above. The population was stratified to allocate the sample size across several strata, as seen in table B.2. Within each stratum, claim groups were sampled with probability-proportional-to-size selection.

Table B.1. Stratification Allocation for Old Contract Claims

Stratum number	Claim population	Number of sampled claims
1	950	10
2	134,386	16
3	5,669	8
4	688	2
5	235	2
6	53,200	8
7	7,555	6
8	134	2
9	171	2
10	6,139	12
11	1,035	6
12	10,359	4
13	575	4
14	3,555	4
15	732	4
16	2,728	10
Total	**228,111**	**100**

Source: VA OIG stratified population. Data were obtained from the contractor and the FSC.

New VA Contract

The team selected a statistical sample of 75 new contract claims with 10 alternate claims from the review population described above. Claims were selected systematically to ensure that no veteran was selected more than once. Specifically, all claims for each veteran were grouped together, and then these groupings were randomly arranged in the sampling frame before the systematic selection.

Weights

Samples for both contracts were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. Specifically, the team estimated the number of mispriced claims as a percentage of total claims by (1) summing the weights of the mispriced claims and (2) dividing this amount by the sum of the weights of all sampled claims.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value approximately 90 percent of the time.

The team employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that 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 the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

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

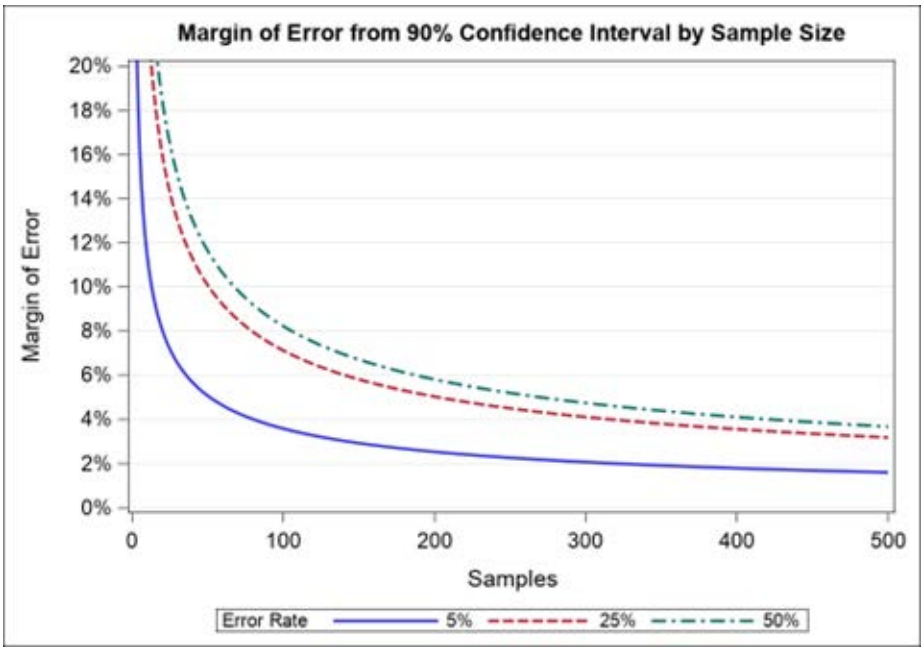

Figure B.1. *Effect of sample size on margin of error.*
Source: VA OIG analysis.

Projections

The projections show the number of mispriced claims as a percentage of all claims. A claim is determined to be mispriced if the difference between the contractor's price and the appropriate price, as determined by the OIG, is greater than 3 percent.

For the old contract only, the percentages were adjusted to account for the fact, as described in the "Population" section above, that many of the population's claims were excluded from the

sampling frame. These exclusions were based on the understanding that these claims were at low risk for error. Because an appropriate projection should be based on the entire population, and not merely those claims that were subject to sampling, the projection in table B.2 is based both on claims included in the sampling frame and on claims excluded from the sampling frame. **Conservatively, all claims excluded from the sampling frame are assumed to be priced correctly.** Tables B.2 and B.3 show the statistical projections for this audit.

Table B.2. Statistical Projections for Accuracy of Old Contract Claims Pricing

Estimate name	Estimate percent	90 percent confidence interval			Sample count*	Sample size‡
		Margin of error	Lower limit	Upper limit		
Mispriced claims	31.6%	13.1%	18.6%	44.8%	47	88

Source: Projections from 100 sampled old contract claims.
** The sample count in this table represents the number of sampled claim groups with a non-zero dollar amount owed to the contractor.*
‡ Although 100 claim groups were sampled and reviewed, 10 of these claim groups pertained to the VA-only stratum (stratum number 16). Based on the team's review of these records, this stratum appears to include claims that are already included in the other strata. Because the claim groups in this stratum had a non-zero probability of selection in other strata, this stratum is disregarded for projection purposes. Of the remaining sample size of 90 claims, one could not be priced, and another was an incorrect claim for which the contractor expected no payment. The resulting sample size is, therefore, 88.

Table B.3. Statistical Projections for Accuracy of New Contract Claims Pricing

Estimate name	Estimate percent	90 percent one-sided confidence interval			Sample count	Sample size
		Margin of error	Lower limit	Upper limit		
Mispriced claims	2.7%	4.3%	NA	7.0%	2	75

Source: Projections from 75 sampled new contract claims.

Appendix C: VA Management Comments

Department of Veterans Affairs Memorandum

Date: August 5, 2024

From: Principal Executive Director, Office of Acquisition, Logistics, and Construction (003) and Chief Acquisition Officer

Subj: Office of Inspector General (OIG) Draft Report: Office of Acquisition, Logistics, and Construction Independent Audit Report of a Dialysis Provider's Contract Pricing and Billing Compliance, 2022-02161-AE-0112 (VIEWS 11932667)

To: Inspector General (50)

1. As requested, the Office of Acquisition, Logistics, and Construction completed its review of the subject OIG draft report and submits the attached comments.

The OIG removed point of contact information prior to publication.

(Original signed by)

Michael D. Parrish, Ph.D.

Attachment

Attachment

Office of Inspector General (OIG) Draft Report

Office of Acquisition, Logistics, and Construction

Independent Audit Report of a Dialysis Provider's

Contract Pricing and Billing Compliance, 2022-02161-AE-0112

Department of Veterans Affairs (VA) Comments

August 2024

Finding 1: Contractor has improved claim pricing accuracy.

VA Comment: VA concurs.

Finding 2: Contractor incorrectly billed local VA facilities $6.4 million.

VA Comment: VA concurs.

OIG made the following recommendations to the contracting officers:

Recommendation 1: Request that the contractor perform a self-audit of local VA claims.

VA Comment: Concur. The National Acquisition Center (NAC) and Strategic Acquisition Center (SAC) will comply by asking [the contractor] to complete the self-audit, to provide the files for all claims filed to local VA Medical Center units. This action applies to both the old contract and the current contract.

Target Completion Date: January 2025.

Recommendation 2: Verify that the contractor has completed the process of refunding local VA claims.

VA Comment: Concur. After careful consideration and based upon the facts presented with analysis of the two contracts, the NAC and SAC recommend the program office, Office of Integrated Veteran Care, be encouraged to review and validate the OIG recommendation of requesting refunds from [the contractor] for claims submitted to the Veterans Health Administration's (VHA) local facilities, prior to acquisitions (NAC/SAC) completing this task. The contracting officer's opinion is that some of the claims presented to VHA local clinics may be valid under a different method of payment such as Veteran Care Agreements, and the Office of Acquisition, Logistics, and Construction is not the authority to validate those claims. However, the NAC and SAC will work with the program office to complete this tasking.

Target Completion Date: January 2025.

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Audit Team	Alyssa Witten, Director Valerie Kimball Clifton Rybick
Other Contributors	Allison Bennett Kendal Ferguson Juliana Figueiredo Charlma Quarles Victor Rhee

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