US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services

Audit | **23-00748-28** | **February 20, 2025**

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Executive Summary

VA can purchase care in the community for veterans in multiple circumstances, including when the care is not available at a VA facility or if the veteran meets wait-time or drive-time standards.[1] Following the VA MISSION Act of 2018, VA launched its Veterans Community Care Program, which consolidated several community care initiatives into one permanent program. This program allows the Veterans Health Administration (VHA) to purchase care for veterans through Community Care Network (CCN) contracts or veterans care agreements.[2] The CCN groups VA medical facilities into five regions managed by two third-party administrators (TPAs)—Optum for regions 1, 2, and 3, and TriWest for regions 4 and 5.[3] The purpose of the CCN is to improve care coordination and make it easier for community providers and VA staff to deliver care to veterans. The TPAs provide administrative and operational support for VHA community care programs, including building the networks, making sure providers are credentialed, and processing and paying provider claims.

The TPAs are responsible for paying community providers the contract-established allowable amounts for healthcare services. VHA then reimburses the TPAs according to the terms of the contract.[4] VHA reimburses hospital care, medical services, and extended-care services up to the maximum allowable rate based on a hierarchy, consisting first of Medicare fee schedule rates; then, if no Medicare rate is available, the local VA fee schedule rate; followed by reimbursement at a percentage of billed charges if no Medicare or VA fee schedule rate is available, although

[1] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393. Under the MISSION Act, veterans are eligible to receive community care under certain circumstances, such as when the veteran's local VA medical facility does not provide the requested service or when a provider determines community care is in the veteran's best medical interest. Consideration is also given to wait times for appointments and the time a veteran spends driving to appointments.

[2] VA medical facilities may enter into local veterans care agreements with community providers in limited situations where contracted services through the CCN are either not provided or not sufficient to ensure veterans can get the care they need. "Community Care," (web page), VA, accessed June 19, 2024, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[3] TPAs are contracted entities that manage a network of providers for VHA community care programs. Each of the five regional contracts began with a base period of up to one year with seven renewable one-year options. According to a VA official, as of fall 2024 the contracts were worth a total of approximately $193.5 billion.

[4] During implementation of the CCN contracts, VHA used a prior community care program—Patient-Centered Community Care—as a bridge until CCN was fully implemented. The deputy under secretary for health for operations and management issued a memorandum on December 20, 2018, stating that the Patient-Centered Community Care contract was preferred routing for community care referrals until the CCN contracts were implemented. Full healthcare delivery occurred as of March 31, 2022. Deputy under secretary for health for operations and management (10N), "Community Care Purchasing Authorities," memorandum to Veterans Integrated Service Network directors (10N1-23), December 20, 2018.

there is no specific percentage identified in the contracts.[5] Dental services are reimbursed to the TPA at rates negotiated and identified in the contracts. The contract requires accurate and timely claim payments to providers from the TPAs and to the TPAs from VHA.

The CCN contracts also state that the reimbursement to the TPAs will be a pass-through for healthcare services under Medicare, the VA fee schedule, and a percentage of billed charges. The term "pass-through" means the TPA seeks reimbursement from VHA for the same amount the TPA paid the community provider for healthcare services, up to the allowed amount in the applicable hierarchy level. Therefore, VHA should not reimburse the TPAs more than the TPAs pay the providers for these services. For dental services in regions 1–4, the contracts do not include the same pass-through language, nor any language specific to whether TPAs can bill VHA for more than they pay community providers. However, the region 5 contract with TriWest does include pass-through language for dental services, so in that region, TriWest is required to seek reimbursement from VHA for the same amount it paid a provider up to the contracted rate.

VHA's Office of Integrated Veteran Care is responsible for overseeing the CCN contracts, TPAs, and contracting officer's representatives. VA's Office of Acquisition, Logistics, and Construction manages VA's contracting, acquisitions, and contract administration and is responsible for administration of the CCN contracts through contracting officers. The procedure in the CCN contracts to ensure proper pricing and payment accuracy is called the agreed-upon procedures audit. According to the CCN contracts, the audit results are intended to be used by VHA to recover overpayments made by the TPAs for healthcare services.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA provided effective oversight of TPAs to ensure accurate and timely payments for CCN outpatient healthcare and dental services made by VHA.[6] This work did not include assessing whether the services provided matched those authorized, which would potentially identify billing for unauthorized services or services outside the scope of the authorization for community care.[7]

What the Audit Found

The OIG estimated that CCN payments to Optum and TriWest were generally accurate and timely.[8] However, inaccurate payments—although a small percentage—resulted in

[5] Because the CCN region 1–4 contracts did not include a percentage of billed charges to limit these transactions, the audit team used VA's reasonable charges schedule to determine a potential reimbursement rate. VA's reasonable charges are based on amounts that third parties reimburse for the same or similar services furnished by private-sector healthcare providers in the same geographic area. The CCN region 5 contract included a maximum allowable fee schedule to limit reimbursements that did not have a Medicare or VA fee schedule rate.

[6] The scope of this audit was limited to outpatient professional and dental transactions and did not include reviewing inpatient care.

[7] See appendix A for the report's scope and methodology.

[8] Appendix B contains information on the OIG's statistical analysis; appendix C explains the monetary benefits.

approximately $105.1 million in overpayments to Optum from fiscal year (FY) 2020 through FY 2022 and $73.4 million in overpayments to TriWest from FY 2020 through FY 2023. This occurred because of ineffective oversight to make sure TPAs were reimbursing at the correct fee schedule rate. In addition, VHA paid Optum approximately $783.4 million more and TriWest about $127.3 million more than the TPAs paid community dental providers for services that occurred from FY 2020 through May 2024.

Community Care Network Payments Were Generally Accurate

The OIG estimated that VHA made accurate payments for outpatient healthcare services for approximately 33.1 million of 33.6 million transactions to Optum from FY 2020 through FY 2022 (98.6 percent), totaling about $5.1 billion of $5.2 billion. The OIG estimated that VHA made accurate payments for outpatient healthcare services for approximately 25 million of 25.1 million transactions to TriWest from FY 2020 through FY 2023 (99.8 percent), totaling about $4.4 billion of $4.5 billion.[9]

Community Care Network Payments Were Mostly on Time

Overall, community providers, VHA, and the TPAs generally met the following timeliness metrics required by the CCN contracts. For payment timeliness, from FY 2020 through FY 2022, the OIG estimated providers submitted claims to Optum within 180 days nearly 99.8 percent of the time. In addition, the OIG estimated Optum paid providers within 30 days about 97.8 percent of the time.[10] Finally, the OIG estimated that VHA reimbursed Optum within 14 days of receiving an invoice about 92.5 percent of the time. From FY 2020 through FY 2023, the OIG estimated that providers submitted claims to TriWest within 180 days nearly 99.9 percent of the time; TriWest paid providers within 30 days about 98.2 percent of the time; and VHA reimbursed TriWest within 14 days of receiving an invoice about 97.4 percent of the time.

Overpayments Occurred Because of the Use of Incorrect Fee Schedules, Lack of a Set Reimbursement for Billed Charges, and Limited Oversight of Healthcare Claims

The OIG estimated that VHA made payment-rate errors on approximately 459,000 of 33.6 million outpatient healthcare service transactions paid to Optum during the review period. The OIG further estimated that VHA made payment-rate errors on approximately 56,200 of 25.1 million outpatient healthcare service transactions paid to TriWest during the review period.

[9] The project's initial scope included Optum through FY 2022. During the audit, the OIG expanded the scope to include TriWest through FY 2023. Throughout the report, totals may not sum due to rounding. For original values and information on the team's statistical analysis, see appendix B.

[10] The OIG audit team relied on payment dates provided by the TPA to determine payment timeliness for TPA-to-provider payments.

The OIG estimated approximately $105.1 million in overpayments to Optum and $73.4 million in overpayments to TriWest. The OIG estimated that most of the overpayments—about $57.5 million for Optum and about $43.7 million for TriWest—occurred because VHA did not reimburse the TPAs at the correct Medicare rate. The OIG estimated that errors of approximately $5.4 million for Optum and $2.2 million for TriWest occurred because VHA did not reimburse the TPAs at the correct VA fee schedule rate. The OIG also estimated that errors of about $42.1 million for Optum and about $27.4 million for TriWest were for payments more than VA's reasonable charges rate schedule for transactions when no applicable Medicare or VA fee schedule rate was available.

The OIG determined that the overpayments occurred for multiple reasons. VHA's Community Care Reimbursement System does not have business rules to validate the reimbursement rate for claims submitted by the TPAs, and the TPAs do not always use the correct contract schedule hierarchy and rates to pay provider claims. In addition, VHA did not establish payment controls in the contracts to limit reimbursements to a percentage of the billed charges when no applicable Medicare or VA fee schedule rate is available. Finally, while the contracting officer's representatives were required to track and validate administrative invoices, that requirement does not exist for healthcare invoices.

Limited Oversight of Community Care Network Contracts Resulted in Excessive Dental Reimbursements

VHA paid Optum approximately $783.4 million more and TriWest about $127.3 million more than the TPAs paid community dental providers for services that occurred from FY 2020 through May 2024. The contracts for regions 1–4 lacked the pass-through language for dental services, which allowed the TPAs to seek reimbursement from VHA for more than they paid providers, up to the contracted rate. Further, an error by the Strategic Acquisition Center's contracting officers during the modification process contributed to approximately $648.7 million of the $783.4 million that VHA paid Optum more than Optum paid community dental providers. As of August 2024, the Strategic Acquisition Center and Integrated External Networks were working to quantify the impact of the dental modification error and pursue any recovery of funds.

What the OIG Recommended

The OIG made seven recommendations, including three to the under secretary for health to develop contract language and/or maximum allowable rates to limit reimbursements for services that do not have a Medicare or VA fee schedule rate; improve oversight of healthcare claim payments to prevent, identify, and recover overpayments in a more timely manner; and consider updating dental contract reimbursement language to limit reimbursements to the amount paid to providers. The OIG also made one recommendation to the chief acquisition officer and principal executive director for the Office of Acquisition, Logistics, and Construction to develop sufficient

oversight and internal controls over the contract modification process to prevent program overpayments. The OIG made three recommendations to both offices to make sure the Office of Integrated Veteran Care and the Office of Acquisition, and Logistics and Construction work together to extend the contracting officer's representatives designated responsibilities to include monitoring of healthcare invoices, explore potential recovery of dental payments to Optum that resulted from VA's Strategic Acquisition Center's error during the contract modification process, and establish effective oversight and internal controls for dental service reimbursements to prevent excessive reimbursements.

VA Management Comments and OIG Response

The under secretary for health concurred with recommendations 1, 2, 4, 6, and 7.[11] The acting principal director of the Office of Acquisition, Logistics, and Construction (also serving as acting chief acquisition officer) concurred with recommendations 5, 6, and 7. Both offices concurred in principle with recommendation 3. VHA provided action plans for all seven recommendations. See appendixes D and E for the full responses from the under secretary and the Office of Acquisition, Logistics, and Construction. The OIG found the action plans acceptable and will monitor progress and close each recommendation when adequate documentation demonstrates sufficient implementation steps have been taken.

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Assistant Inspector General
for Audits and Evaluations

[11] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 17, 2024.

Contents

Abbreviations

CCN	Community Care Network
CLIN	contract line item number
COR	contracting officer's representative
FAR	Federal Acquisition Regulation
FY	fiscal year
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
TPA	third-party administrator
VHA	Veterans Health Administration

Introduction

The VA MISSION Act of 2018 consolidated several community care initiatives into one permanent program.[12] Since the consolidation, the Veterans Health Administration (VHA) may purchase care for veterans through Community Care Network (CCN) contracts or local veterans care agreements. VHA uses the CCN contracts to purchase care for veterans in their community, while veterans care agreements can be used by local VA medical facilities for services that are not available through the CCN.[13] The CCN groups VA medical facilities into five regions managed by two third-party administrators (TPAs)—Optum for regions 1, 2, and 3, and TriWest for regions 4 and 5—that VA contracts with to purchase care for veterans from community providers.[14] The purpose of the CCN is to improve care coordination and make it easier for community providers and VA staff to deliver care to veterans.

The VA Office of Inspector General (OIG) conducted this audit to determine whether VHA provided effective oversight of TPAs to ensure accurate and timely payments for CCN outpatient healthcare and dental services made by VHA. This work did not include assessing whether the services provided matched those authorized, which would potentially identify billing for unauthorized services or services outside the scope of the authorization for community care.

Community Care Eligibility

Under the MISSION Act, veterans are eligible to receive community care in multiple circumstances, including the following:[15]

- The veteran's local VA medical facility does not provide the requested services.
- The veteran lives in a US state or territory without a full-service VA medical facility.

[12] John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393. Under the MISSION Act, veterans are eligible to receive community care under certain circumstances, such as when the veteran's local VA medical facility does not provide the required service or when a provider determines community care is in the veteran's best medical interest. Consideration is also given to wait times for appointments and the time a veteran spends driving to appointments.

[13] VA medical facilities may enter into local veterans care agreements with community providers in limited situations where contracted services through the CCN are either not provided or not sufficient to ensure veterans can get the care they need. "Community Care," (web page), VA, accessed June 19, 2024, https://www.va.gov/COMMUNITYCARE/providers/Veterans-Care-Agreements.asp.

[14] TPAs are contracted entities that provide and manage a regional network of providers for VHA community care programs. Each of the five regional contracts began with a base period of up to one year with seven renewable one-year options. According to a VA official, as of fall 2024 the contracts were worth a total of approximately $193.5 billion.

[15] MISSION Act; 38 U.S.C. § 1703(d); 38 C.F.R. §§ 17.4010 and 17.4040 (2023); VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

- The medical service line (for example, cardiology) at the local VA medical facility does not meet VA's defined quality standards for that service line.
- The veteran's referring provider, with agreement from the veteran, determines community care is in the veteran's best medical interest.
- The veteran must drive at least 30 minutes for primary care or mental health care or 60 minutes for specialty care to get to a VA medical facility.
- The veteran's wait time for an appointment at a local VA medical facility or clinic is more than 20 days for primary care and mental health care or 28 days for specialty care.

VHA Community Care Networks

In December 2018, VA awarded contracts to Optum to serve as the TPA for regions 1, 2, and 3. In 2019, TriWest was awarded a contract to serve as the TPA for region 4, followed by a contract for region 5 in 2020. TPAs provide administrative and operational support for the VHA Community Care Network, including building the networks, making sure providers are credentialed, and processing and paying provider claims. VHA reimburses TPAs for the payments they make to providers.[16] Under Optum, regions 1–3 achieved full healthcare delivery in fiscal year (FY) 2020, along with TriWest's region 4. Region 5 achieved full healthcare delivery in FY 2021.[17]

VHA paid Optum approximately $5.2 billion for CCN outpatient healthcare claims from FY 2020 through FY 2022. VHA paid TriWest approximately $4.5 billion for CCN outpatient healthcare claims from FY 2020 through FY 2023.[18] Figure 1 (on the next page) identifies all outpatient claim payments VHA made to the TPAs by payment date and region for these years.[19]

[16] During implementation of the CCN contracts, VHA used a prior community care program—Patient-Centered Community Care—as a bridge until CCN was fully implemented. The deputy under secretary for health for operations and management issued a memorandum on December 20, 2018, stating that the Patient-Centered Community Care contract was preferred routing for community care referrals until the CCN contracts were implemented. Full healthcare delivery occurred as of March 31, 2022. Deputy under secretary for health for operations and management (10N), "Community Care Purchasing Authorities," memorandum to Veterans Integrated Service Network directors (10N1-23), December 20, 2018.

[17] Appendix A includes a map of the regions and TPAs.

[18] Region 5, Alaska, accounted for only $100.4 million in total outpatient expenditures through FY 2023.

[19] These were the most recent fiscal years with completed claims data when the analyses for this audit were conducted. The Optum analyses included data through FY 2022; when the scope was expanded to include TriWest, FY 2023 data were available, so the team expanded the scope to include TriWest through FY 2023.

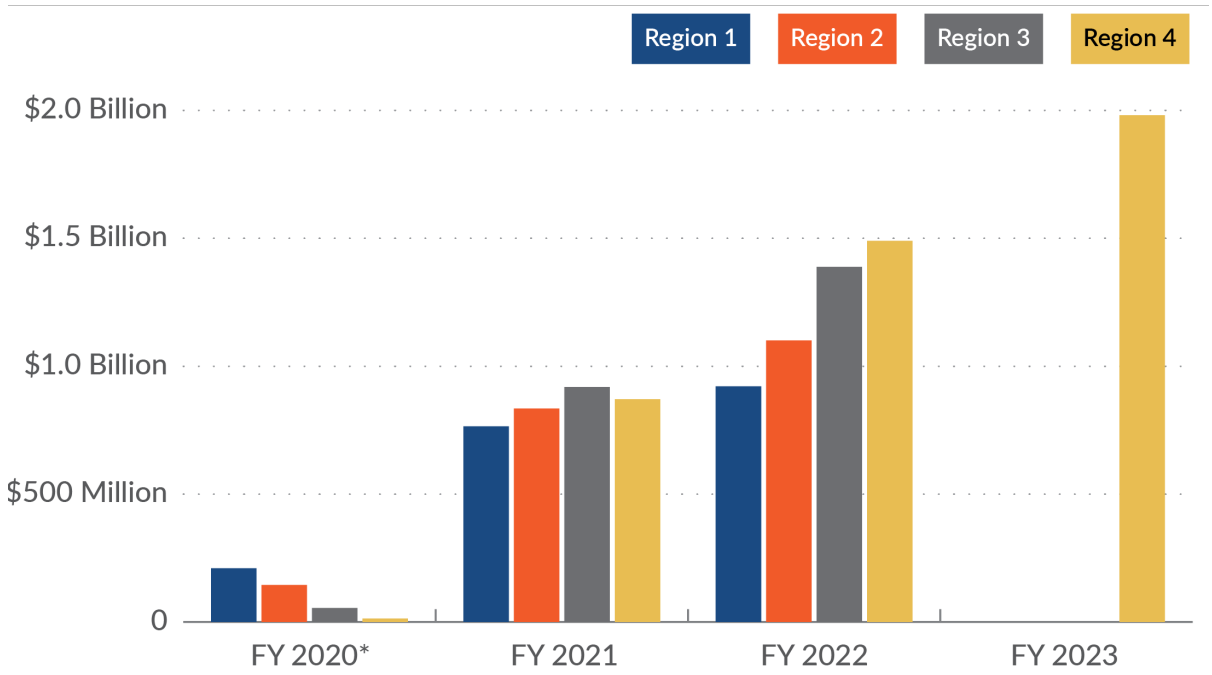

Figure 1. *VHA outpatient claim payments to Optum for CCN regions 1–3, FY 2020 through FY 2022 and to TriWest for CCN region 4, FY 2020 through FY 2023.*

Source: Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4) and from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023 (quarter 4).

** Full implementation dates for the CCN contracts varied by region from FY 2020 through FY 2022. For region 5, outpatient claim payments to TriWest totaled about $100.4 million through FY 2023.*

VHA paid Optum approximately $2 billion and paid TriWest about $403 million for CCN dental claims from FY 2020 through May 2024. Figure 2 (on the next page) identifies all dental claim payments made to Optum and TriWest by payment date for these years.[20]

[20] The audit team analyzed the full universe of dental claims through May 2024 because this universe was small enough to be analyzed without sampling.

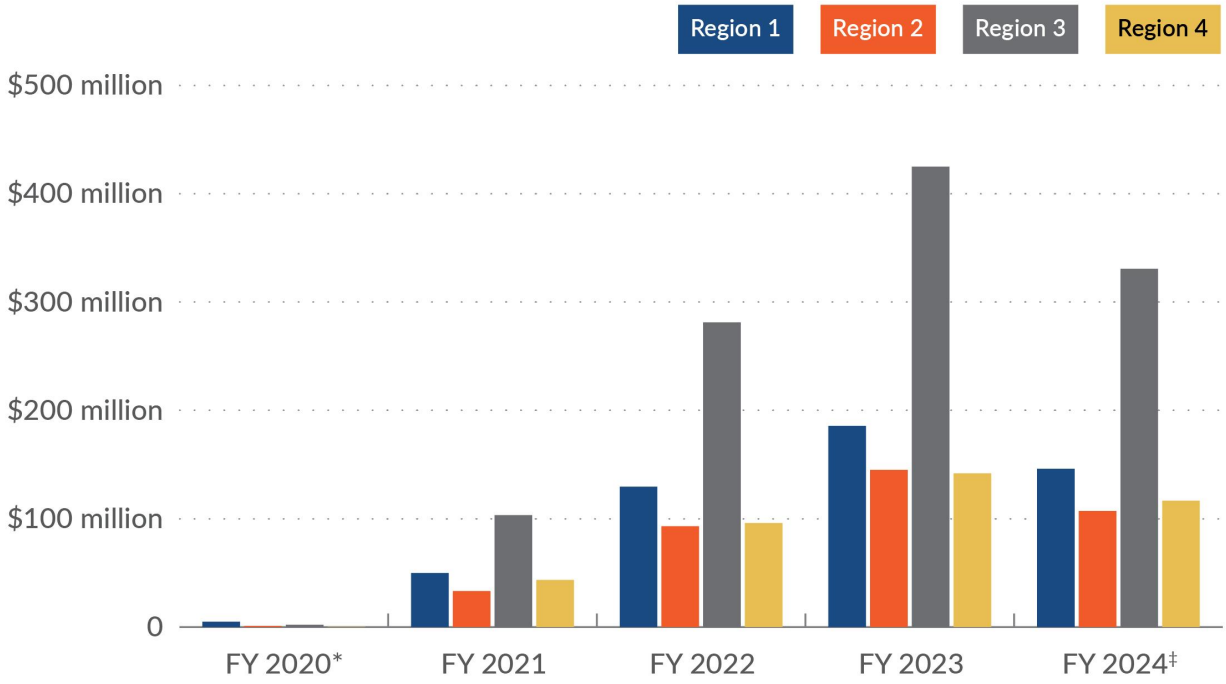

Figure 2. *VHA dental claim payments to Optum for CCN regions 1–3 and to TriWest for CCN region 4, FY 2020 through May 2024.*

Source: Community Care Reimbursement System dental payment data from the Corporate Data Warehouse for Optum and from the Corporate Data Warehouse for TriWest from FY 2020 through May 2024.

** Full implementation dates for the CCN contracts varied by region from FY 2020 through FY 2022. For region 5, dental claim payments to TriWest totaled about $4,658,757 through May 2024.*

‡ Fiscal years run from October through September; therefore, the data from FY 2024 through May are from the first eight months of that fiscal year.

Payment Timeliness

The CCN contracts establish time periods for the TPAs to pay community providers and for VHA to reimburse the TPAs. The contracts require providers to submit claims to the TPAs within 180 days. The contracts also state the TPAs must pay the provider within 30 days of the receipt of the provider's claim, and VHA must pay the TPAs within 14 days of receiving the reimbursement invoice.[21] Payments made beyond the contract-allowed time period are considered late payments. Figure 3 (on the next page) illustrates the CCN contract timeliness metrics.

[21] No consequences exist for VHA if they do not reimburse a TPA within the 14-day requirement.

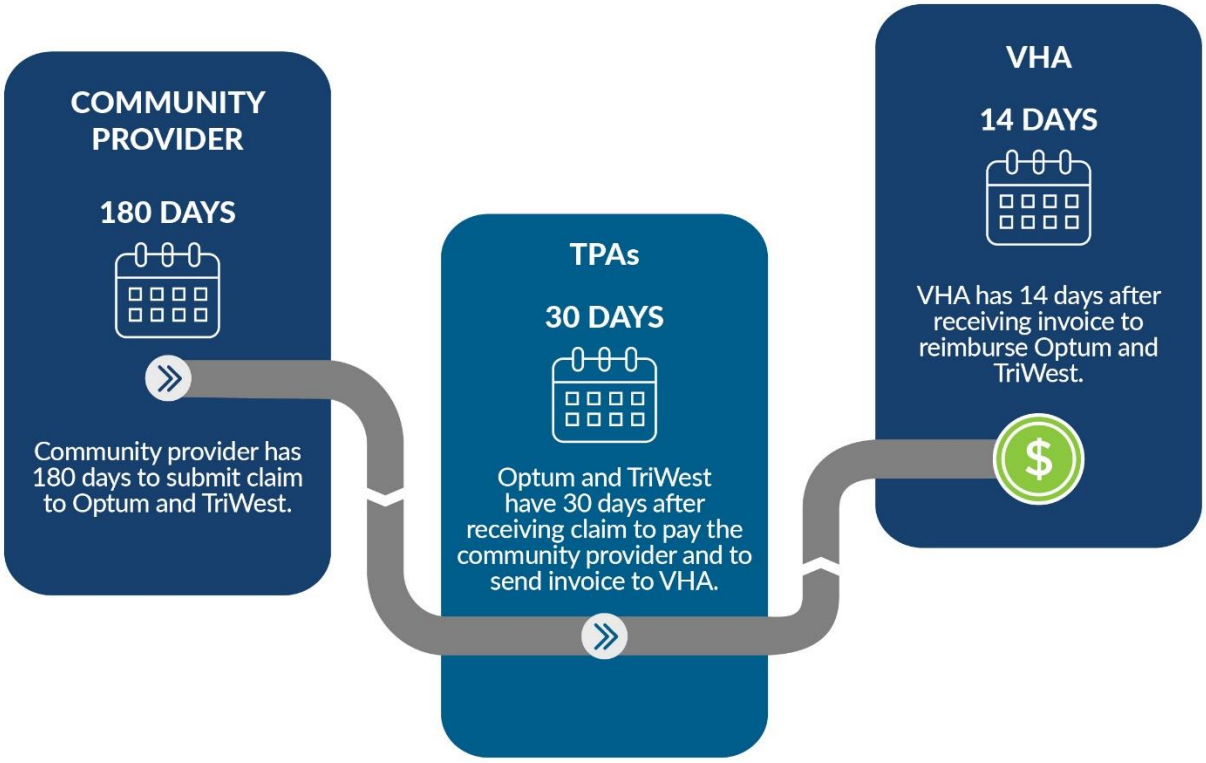

Figure 3. *CCN contract timeliness metrics.*
Source: VA OIG analysis of the Performance Work Statements for CCN regions 1–5 contracts.

Payment Accuracy

TPAs are responsible for paying community providers the contract-established allowable amounts for healthcare services. VHA should then reimburse the TPAs the amount paid to the providers up to the applicable contract rate for the services.[22] The CCN contracts identify the methodology that defines reimbursement rates for health care delivered by community providers. VHA reimburses hospital care, medical services, and extended-care services up to the maximum allowable rate. This methodology follows a specific payment hierarchy, starting with the Medicare fee schedule rate and then moving to the local VA fee schedule rate if the Medicare rate is unavailable. If neither is available, reimbursement will be made at a percentage of billed charges, although there is no specific percentage identified in the contracts.[23] Dental services are

[22] According to the CCN contracts, when the TPAs bill less than the applicable contract rates, the rate billed is then accepted as a onetime automatic adjustment to the negotiated contract rates and are not considered underpayments.

[23] Region 1–4 contracts identify the Medicare fee schedule as contract line item number (CLIN) 1, the VA fee schedule as CLIN 6, and the percentage of billed charges as CLIN 7. Region 5, Alaska, follows the payment hierarchy of Medicare, VA fee schedule, Alaska Maximum Allowable Charges Schedule, and then a percentage of billed charges.

reimbursed to the TPA at a rate negotiated and identified in each region's contract. The payment reimbursement hierarchy is shown in figure 4.

Figure 4. *CCN claims reimbursement payment hierarchy, regions 1–4.*
Source: VA OIG analysis of the Performance Work Statements for CCN regions 1–5 contracts.
**Region 5, Alaska, includes an additional maximum allowable charges schedule.*

Pass-Through Payments

The CCN contracts state that VHA's reimbursements to the TPAs will be pass-through payments for healthcare services based on the hierarchy established in the previous section. The term "pass-through" means the TPA seeks reimbursement from VHA for the same amount the TPA paid the community provider for healthcare services, up to the allowed amount in the applicable hierarchy level. Therefore, for these services VHA should not reimburse the TPAs more than they pay the providers. For dental services in regions 1–4, the contracts do not include the same pass-through language or any language specific to whether TPAs can bill VHA for more than they pay community providers. However, the region 5 contract with TriWest does include pass-through language for dental services.

Community Care Reimbursement System

The Community Care Reimbursement System is the automated processing system for CCN claims, including dental claims. TPAs submit healthcare claim information electronically to VHA, and when the Community Care Reimbursement System receives the healthcare claim information, it is then processed as an invoice for reimbursement. When the system processes the healthcare services information, it does not check the invoice for the established rate. The system does not include business rules to review the invoice for the correct Medicare, VA fee schedule, dental, or other contract rates. Instead, VHA relies on the TPAs to process provider claims at the correct contract rate and reimburses each TPA through the Community Care Reimbursement System at the TPA's invoiced charges.

Administrative Services: Per Member Per Month Model

According to the contracts, the TPAs are paid a fee for administrative services based on a "per member per month" model for healthcare and dental services. This covers the TPAs charges for

administrative services for managing the contracts. The TPAs are paid in accordance with the total number of active veterans per month. The "per member per month" model is tiered to accommodate for low volumes, and then as volume increases the per member fee is reduced.

Agreed-upon Procedures Audit and Overpayment Recovery Process

The procedure in the CCN contracts to ensure proper pricing and payment accuracy is called the agreed-upon procedures audit. Specifically, the contracts require TPAs to hire a third-party auditor to conduct quarterly reviews to make sure the TPAs invoice VHA in accordance with the contract rates and payment guidelines for all types of healthcare services.[24] According to the CCN contracts, VHA should use the audit results to recover overpayments that TPAs made for healthcare services and submitted for reimbursement to VHA. VHA may also use the audit results to apply incentives or disincentives for payment accuracy; however, during the scope of the audit, VHA had not awarded any incentives or applied any disincentives for payment accuracy.[25]

Program Oversight

National oversight of the CCN is split among VHA and VA offices, with performance monitoring provided by contracting officers and contracting officer's representatives (CORs).

VHA Office of Integrated Veteran Care

According to VHA's Office of Healthcare Transformation, VHA completed a reorganization of its Office of Community Care and Office of Veterans Access to Care and formally established its Office of Integrated Veteran Care (IVC) in June 2022. According to VHA, the establishment of IVC was intended to provide coordination across facility and community care access functions.

In addition, IVC's Office of Internal Review and Oversight is responsible for "promoting a culture of integrity, assisting VHA to identify, assess and appropriately respond to compliance risks" across the VHA.[26]

[24] These reviews use a statistical sampling plan to project improper payments for all types of health care provided under the CCN contract to be used by VA for recovery purposes.

[25] The actual incentive and disincentives are based on overall payment error rates across outpatient, inpatient, and dental services. During the scope of the audit, VHA had not calculated any incentives or disincentives for the region 1–5 contracts. As of January 2024, VHA has completed contract modifications for TriWest to update the incentive and disincentive calculation process, and Integrated External Networks was beginning the process to implement incentives and disincentives. According to a director from Integrated External Networks, the contract modification for Optum to update the incentive and disincentive factors is still in negotiation.

[26] "About Us" (website), IVC Office of Internal Review and Oversight, dvagov.sharepoint.com/sites/vhaoivccompliance. (This website is not publicly accessible.)

IVC is organized in four organizational groups. The group responsible for overseeing the CCN contracts is the Office of Integrated External Networks. A key responsibility of this office is to develop, oversee, and monitor the contracts for veterans' healthcare services. According to an Integrated External Networks official, this included ensuring that Optum and TriWest are paid accurately and on time.

Within IVC's Office of Integrated External Networks, the Contract Management and Performance Division assigns CORs to assist in the technical monitoring or administration of a contract.[27] According to IVC, as of April 2024, Integrated External Networks had 15 CORs assigned to the CCN contracts together with the Strategic Acquisition Center.[28] The Contract Management and Performance Division is responsible for the acceptance or rejection of CCN contract deliverables, including the agreed-upon procedures audits. Additionally, they rely on IVC's Internal Review and Oversight to review the agreed-upon procedures audits and attest to the results.

VA Office of Acquisition, Logistics, and Construction

This office manages VA's contracting, acquisitions, and contract administration. Within this office, the Strategic Acquisition Center primarily supports VHA procurement needs by awarding contracts and is responsible for administration of the CCN contracts. An assigned contracting officer supports the day-to-day administration and is responsible for ensuring the performance of all necessary actions, compliance with the terms of each contract, and safeguarding VA's interests.[29] The Strategic Acquisition Center designates CORs that are nominated by IVC's Integrated External Networks. Each COR is assigned to a contract and helps administer it, such as by tracking and validating invoices received and certification of payment, resolving invoice discrepancies with the TPAs, and confirming availability of funds. Figure 5 (on the next page) shows the VA Office of Acquisition, Logistics, and Construction offices involved in contract procurement and administration.

[27] FAR 1.604 (2024) defines a COR's role.

[28] FAR 2.101 (2024). Contracting officer's representative means an individual, including a contracting officer's technical representative, designated and authorized in writing by the contracting officer to perform specific technical or administrative functions.

[29] FAR 2.101. Contracting officer means a person with the authority to enter into, administer, and/or terminate contracts and make related determinations and findings. The term includes certain authorized representatives of the contracting officer acting within the limits of their authority as delegated by the contracting officer.

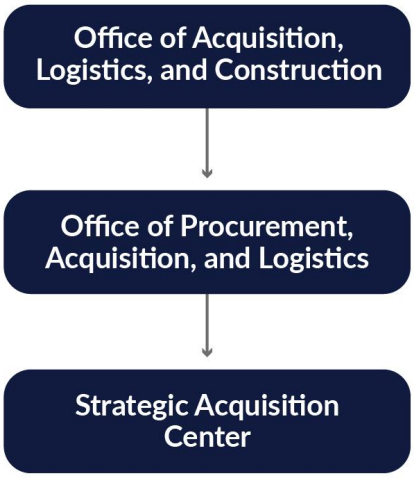

Figure 5. *VA offices involved in CCN contracts.*
Source: VA.gov.

Results and Recommendations

Finding 1: VHA and TPA Payments for Outpatient Healthcare Services Were Mostly Accurate and Timely, but Overpayments Could Be Minimized with Additional Payment-Rate Controls

The OIG estimated that VHA made accurate payments for outpatient healthcare services for approximately 33.1 million of 33.6 million transactions to Optum from FY 2020 through FY 2022 (98.6 percent), totaling about $5.1 billion of $5.2 billion. The OIG also estimated that VHA made accurate payments for outpatient healthcare services for approximately 25 million of 25.1 million transactions to TriWest from FY 2020 through FY 2023 (99.8 percent), totaling about $4.4 billion of $4.5 billion.[30]

Community providers, VHA, and the TPAs generally met the contractually required payment timeliness metrics required by the CCN contracts for regions 1–5. For Optum, from FY 2020 through FY 2022, the OIG estimated providers submitted claims within 180 days nearly 99.8 percent of the time. In addition, according to the OIG's assessment, Optum paid providers within 30 days about 97.8 percent of the time, and VHA reimbursed Optum within 14 days of receiving an invoice about 92.5 percent of the time.[31] For TriWest, from FY 2020 through FY 2023, the OIG estimated that providers submitted claims within 180 days nearly 99.9 percent of the time; TriWest paid providers within 30 days about 98.2 percent of the time; and VHA reimbursed TriWest within 14 days of receiving an invoice about 97.4 percent of the time.

VHA payments for outpatient healthcare services were mostly accurate. The OIG estimated that VHA made payment-rate errors on about 459,000 of 33.6 million of these transactions paid to Optum and 56,200 of 25.1 million paid to TriWest. Although the percentage of errors was small, the amount of transactions means this resulted in an estimated $105.1 million and $73.4 million in overpayments to Optum and TriWest, respectively. According to the OIG's assessment, most of these overpayments—about $57.5 million for Optum and $43.7 million for TriWest—occurred because VHA did not reimburse the TPAs at the correct Medicare rate.[32] However, some errors occurred because VHA did not reimburse the TPAs at the applicable VA fee schedule rate, resulting in overpayments of about $5.4 million for Optum and $2.2 million for TriWest. The OIG also estimated that errors of about $42.1 million in overpayments for Optum and $27.4 million for TriWest occurred because no applicable Medicare or VA fee schedule rate

[30] The project's initial scope included Optum through FY 2022. During the audit, the OIG expanded the scope to include TriWest through FY 2023.

[31] The OIG audit team relied on payment dates provided by the TPA to determine payment timeliness for TPA-to-provider payments.

[32] This report uses rounded values, which may not sum due to rounding. For more information on the team's statistical analysis, see appendix B.

was available. The OIG team used VA's reasonable charges schedule to determine a potential reimbursement rate for transactions without a Medicare or VA fee schedule rate.

Despite VHA's accuracy regarding these transactions, the OIG identified opportunities to further reduce overpayments. VHA's Community Care Reimbursement System does not have business rules to validate the reimbursement rate for claims submitted by the TPAs, which do not always ensure that provider claims use the correct contract schedule hierarchy and rates. In addition, VHA did not establish payment controls in the contracts to limit reimbursements to a percentage of the billed charges when no applicable Medicare or VA fee schedule rate was available. Finally, while the CORs are required to track and validate administrative invoices, that requirement does not exist for healthcare invoices.

The OIG also determined that VHA has made some overpayment recoveries through the agreed-upon procedures audits but still needs to complete the remaining recoveries from FY 2020 through FY 2022 (for Optum) and FY 2021 through FY 2023 (for TriWest).

The following determinations support the OIG's finding:

- VHA reimbursed TPAs accurately for most outpatient services.
- Community Care Network payments were mostly on time.
- Overpayments occurred because of the use of incorrect fee schedules, lack of a set reimbursement percentage for billed charges, and limited oversight of healthcare claims.

What the OIG Did

The OIG team conducted site visits to IVC's Integrated External Networks office in Denver, Colorado, and the Strategic Acquisition Center in Fredericksburg, Virginia. The team also interviewed VHA program officials responsible for the administration of the CCN program and Optum officials.

To assess payment accuracy, the team reviewed a sample of CCN outpatient professional transactions for Optum and TriWest. The Optum transactions were paid from FY 2020 through FY 2022, and the TriWest transactions were paid from FY 2020 through FY 2023 through the Community Care Reimbursement System.[33] The team reviewed a sample of 600 transactions for outpatient professional healthcare services from a universe of about 33.6 million transactions from Optum and a sample of 600 transactions from a universe of about 25.1 million transactions

[33] These were the most recent fiscal years with completed claims data when the analyses for this audit were conducted. The Optum analyses included data through FY2022; when the scope was expanded to include TriWest, FY 2023 data were available, so the team expanded the scope to include TriWest through FY 2023.

from TriWest.[34] For both TPAs, the OIG team reviewed 200 transactions from each reimbursement rate the TPA used to invoice for reimbursement. The hierarchy of these rates, first to last, are as follows:

- **Medicare:** healthcare services in which payment can be up to Medicare rates
- **VA fee schedule:** non-Medicare healthcare services in which payment is based on the applicable VA fee schedule rate and should be used only when no Medicare rate is available
- **Percentage of billed charges:** non-Medicare, non-VA fee schedule healthcare services in which payment should be based on a percentage of billed charges; should be used only when no Medicare or VA fee schedule rate is available

Since the CCN contracts for regions 1–4 did not include a percentage of billed charges to limit transactions, without a Medicare or VA fee schedule rate, the OIG team used VA's reasonable charges schedule to determine a potential reimbursement rate. VA's reasonable charges are based on amounts that third parties reimburse for the same services furnished by private-sector healthcare providers in the same geographic area. The CCN region 5 contract included a maximum allowable fee schedule to limit reimbursements that did not have a Medicare or VA fee schedule rate.

To assess timeliness, the team reviewed 797 unique claims representing a sample of 800 outpatient and dental transactions from a universe of about 35 million transactions from Optum from FY 2020 through FY 2022 and 800 unique claims representing a sample of 800 outpatient and dental transactions from a universe of about 26.2 million transactions from TriWest from FY 2020 through FY 2023.

VHA Reimbursed TPAs Accurately for Most Outpatient Services

The OIG estimated that VHA made accurate payments for outpatient healthcare services for approximately 33.1 million of 33.6 million transactions to Optum from FY 2020 through FY 2022 (98.6 percent), totaling about $5.1 billion of $5.2 billion. The OIG also estimated that VHA made accurate payments for outpatient healthcare services for approximately 25 million of 25.1 million transactions to TriWest from FY 2020 through FY 2023, totaling about $4.4 billion of $4.5 billion (99.8 percent).

[34] The audit sample included 600 outpatient transactions and 200 dental transactions, for a total of 800 line-item transactions for each TPA. That resulted in 797 unique claims for Optum and 800 unique claims for TriWest. A claim can have one or more transactions.

Community Care Network Payments Were Mostly on Time

The OIG found that community providers, TPAs, and VHA generally met the timeliness metrics set by the CCN contracts for outpatient healthcare and dental claims. The contracts require providers to submit claims to the TPAs within 180 days from the date of service or date of discharge to meet the filing deadline. Then the TPAs pay the providers and submit invoices to VHA for reimbursement within 30 days.[35] If the provider does not meet the 180-day deadline, the TPA should deny the claim.

Once VHA receives an invoice from a TPA, the contracts require VHA to reimburse the TPA within 14 calendar days. Figure 6 provides an overview of the OIG's estimate of payment timeliness for all five regions.

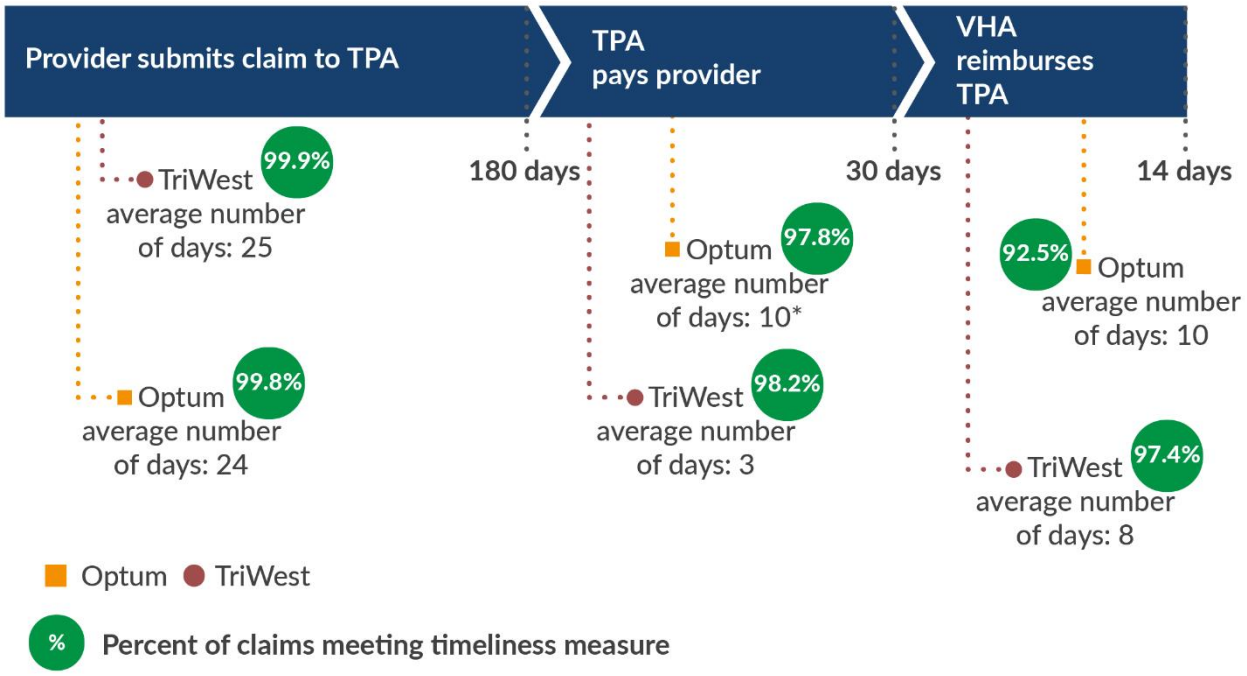

Figure 6. *Estimate of Optum regions 1–3 and TriWest regions 4–5 payment timeliness for outpatient healthcare services.*

Source: VA OIG statistical projections based on a sampled universe of Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4) and from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023.

** The OIG was unable to obtain a date of payment to the provider from Optum for one claim in the sample.*

[35] TPAs must process and certify 98 percent of all clean claims, including resubmissions, within 30 days of receipt. A clean claim is one that contains all the required data elements necessary for the TPA to certify and pay the provider for the claim. The TPA then invoices VHA for reimbursement.

Overpayments Occurred Because of the Use of Incorrect Fee Schedules, Lack of a Set Reimbursement Percentage for Billed Charges, and Limited Oversight of Healthcare Claims

Although most payments were accurate, the sheer number of CCN transactions that VHA must reimburse means that overpayments for even a small percentage add up over several fiscal years. The OIG estimated that, during the review period, VHA overpaid Optum on approximately 459,000 transactions and TriWest on approximately 56,200 transactions—resulting in overpayments of about $105.1 million and $73.4 million, respectively.

Overpayments occurred because of the use of incorrect fee schedule rates, the lack of a set reimbursement percentage for billed charges, and limited oversight of healthcare claims. VHA relies on the TPAs to process provider claims for healthcare services and submit invoices to VHA for reimbursement through the Community Care Reimbursement System. The system then pays TPAs at invoiced charges without verifying the correct contract payment rates. In addition, VHA relies on CORs to ensure compliance with the terms of the contract; however, according to an Integrated External Networks director and multiple CORs, they were not specifically assigned responsibility to review the accuracy of healthcare invoice payments.

Medicare Rate Overpayments

The OIG estimated VHA Medicare rate overpayments to Optum were approximately $57.5 million of $5.2 billion for outpatient transactions. The OIG estimated VHA Medicare rate overpayments to TriWest were approximately $43.7 million of about $4.5 billion for outpatient transactions. These overpayments occurred when TPAs did not use the appropriate Medicare rate when one was available.

VA Fee Schedule Overpayments

The OIG estimated VA fee schedule rate overpayments to Optum were approximately $5.4 million of $5.2 billion for outpatient transactions. The OIG estimated VA fee schedule overpayments to TriWest were approximately $2.2 million of $4.5 billion for outpatient transactions. These overpayments occurred when the VA payments to the TPAs exceeded the appropriate VA fee schedule rate.[36]

Billed Charge Overpayments

The CCN contracts for regions 1–4 discuss limiting healthcare claim payments based on a percentage of billed charges, but they do not define a percentage to apply to these transactions; in

[36] When there is no Medicare rate available, the VA fee schedule dictates the maximum allowable rate for CCN providers.

other words, no contractual rate control existed for these transactions in regions 1–4. Instead, VHA reimbursed Optum's and TriWest's invoiced charges without a contractual rate control to limit those charges. As of August 2024, VHA had not taken action to establish a rate control in the current CCN contracts to limit reimbursements without a Medicare or VA fee schedule rate.

VHA did not establish payment controls for healthcare services without a Medicare or VA fee schedule rate paid by Optum, leading to an estimated $42.1 million of $5.2 billion paid over the reasonable charges rate.[37] For TriWest, an estimated $27.4 million of $4.5 billion was paid over the reasonable charges rates.[38] When the amount VHA reimbursed the TPAs was greater than the VA reasonable charges rate, the OIG considered it an overpayment.

In examples 1 and 2, VHA paid more than VA's reasonable charges rates for healthcare transactions and missed an opportunity to save VA money by not limiting reimbursements.

Example 1

Optum billed, and VHA paid, $156,032 for a healthcare service code for skin substitutes. The audit team identified a lower rate for this procedure based on VA's reasonable charges of $5,146.48. VHA missed an opportunity to save $150,885.52 by not including a rate control in the contract that could limit reimbursements for healthcare services that do not have a Medicare or VA fee schedule rate.

Example 2

TriWest billed, and VHA paid, $10,400 for a healthcare service code for intravenous injection. The audit team identified a lower rate for this procedure based on VA's reasonable charges of $272.80. VHA missed an opportunity to save $10,127.20 by not including a rate control in the contract that could limit reimbursements for healthcare services that do not have a Medicare or VA fee schedule rate.

Figure 7 (on the next page) summarizes the estimated amounts paid that were more than VA's reasonable charges schedules.

[37] Medicare and VA fee schedule rates are payment-rate controls established in the contract used between VA and the contractors.

[38] To calculate cost savings for transactions without a Medicare or VA fee schedule rate, the audit team used VA's reasonable charges rate schedules, as OIG has done in prior work related to payments for community care. VA's reasonable charges are based on amounts that third parties reimburse for the same services furnished by private sector healthcare providers in the same geographic area. VA publishes reasonable charges annually in the Federal Register to inform the public of the amount VA's Revenue Operations will collect or recover for medical care or services provided or furnished to a veteran for non–service-connected care.

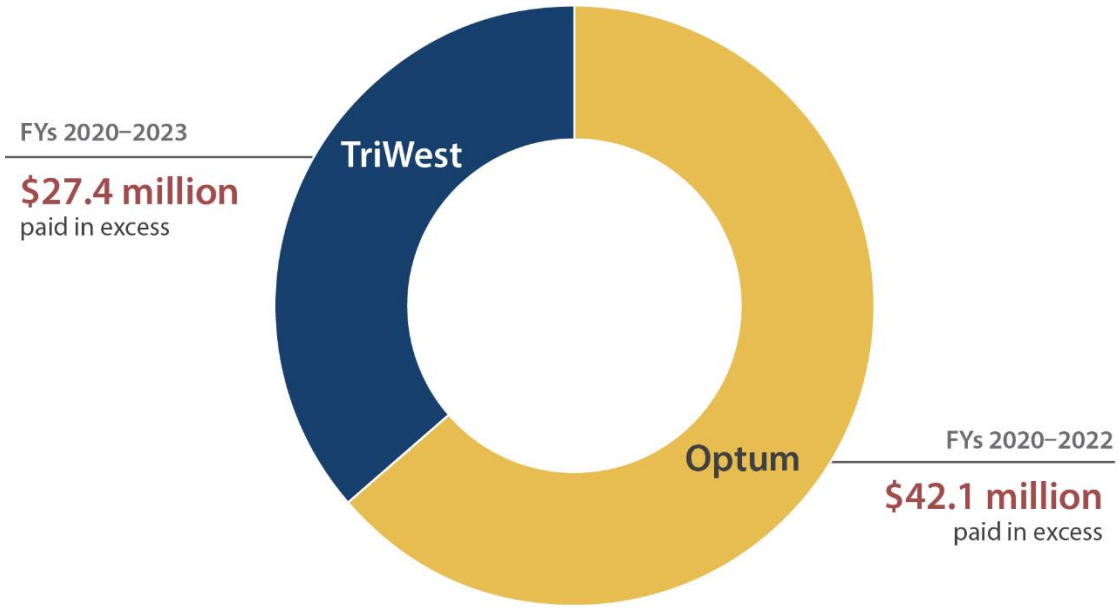

Figure 7. *Estimated amount paid to TPAs exceeding VA's reasonable charges.*

Source: VA OIG statistical projections based on a sampled universe of Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4) and from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023 (quarter 4).

Within VHA's CCN, the region 5 contract includes unique contract language that limits reimbursements for healthcare services that do not have a Medicare or VA fee schedule rate to a maximum allowable schedule. This schedule of rates is updated annually and included as an attachment to the region 5 contract. According to the region 5 contracting officer, the schedule was established by the program office to capture services authorized but not included on the VA fee schedule. The OIG team did not identify any overpayments in region 5.

Additional Oversight to Further Reduce the Risk of Overpayments

VHA's Community Care Reimbursement System does not include business rules to review an invoice for the correct Medicare, VA fee schedule, dental, or other contract rates. Instead, VHA relies on the TPAs to process claims for healthcare services at the correct contract rate and reimburses the TPAs through the reimbursement system at billed charges.

According to the Federal Acquisition Regulation, contracting officers are responsible for "ensuring performance of all necessary actions for effective contracting, ensuring compliance with terms of the contract, and safeguarding the interests of the United States in contractual relationships."[39] Contracting officers can designate CORs to assist with technical functions in

[39] FAR 1.602 (2024).

administering the contracts.[40] The OIG team reviewed appointment letters for CORs responsible for reviewing invoices for the CCN contracts from FY 2020 through FY 2023 for the TPAs. It found that the representatives were not specifically assigned responsibility to review the accuracy of healthcare invoice payments; the appointment letters only included the responsibility to track and validate the contracts' administrative invoice payments.[41] IVC's Integrated External Networks director who was over contracts management in FY 2022, and therefore was responsible for overseeing the CORs, confirmed that CORs did not review healthcare invoices and saw this as a duty that could be added in the future. In addition, contracting officers from the Strategic Acquisition Center acknowledged that COR oversight for healthcare invoice payments had been a previous point of discussion with Integrated External Networks. But both offices lacked resources to take any action and, according to an Integrated External Networks director, the CORs were not equipped with the technical expertise.

VHA Recoveries of Overpayments

The contracts require TPAs to hire a third party to conduct quarterly agreed-upon procedures audits to identify opportunities to recover overpayments. The third-party auditor selects a sample from the total quarterly payments for healthcare services from each region and then identifies overpayment errors within each selected sample.[42] When the TPA acknowledges the overpayment errors found in the sample provided by the third-party auditor, the TPA then identifies additional invoices with the same type of errors in the quarterly total.

The TPA must then provide the total overpayments for the quarter to IVC's Integrated External Networks Contract Management and Performance Division using the Overpayments Electronic File (overpayment file) for VHA to recover. There is an overpayment file for each region, for each quarter—for example, Optum would provide 12 overpayment files to IVC per year for regions 1–3.

The CORs from Integrated External Networks Contract Management and Performance are responsible for monitoring contract financial management controls and for reviewing and certifying acceptance of the overpayment files. After receiving the overpayment files from the TPA, the CORs delegate the Office of Internal Review and Oversight to reconcile the document with the adjusted claims. Once the overpayment file is reconciled, the COR will certify acceptance of the file.

[40] FAR 2.101.

[41] The contract provides payment to TPAs for administrative services they provide and bill through administrative invoices. Examples include administrative services for healthcare services, dental, and pharmacy benefits management such as appointment scheduling, or referral management.

[42] The agreed-upon procedures audits include reviews of healthcare transactions for institutional, professional, dental, and pharmacy claims. The scope of this review was outpatient professional claims.

As of April 2024, the Office of Internal Review and Oversight had reconciled a majority of the overpayment files; however, the office could not reconcile all the overpayment files due to a sequencing issue between the original and adjusted claims.[43] In addition, the office was continuing to work through overpayment files affected by the sequencing issue.

As of March 2024, IVC reconciled 28 of 35 overpayment files for Optum (80 percent).[44] Additionally, as of April 2024, IVC reconciled 14 of 21 overpayment files (67 percent) from TriWest.[45]

The OIG estimated overpayments of about $105.1 million to Optum from FY 2020 through FY 2022 for outpatient healthcare services, of which IVC recovered about $14 million. TriWest's overpayments for outpatient healthcare services were estimated at about $73.4 million from FY 2020 through FY 2023, with IVC recovering about $75,400.

The OIG determined IVC has confirmed some monetary overpayment recoveries through the agreed-upon procedures audits. However, the overpayment recoveries are significantly less than the OIG's estimates. This occurred because IVC relied on TPAs to determine overpayment amounts and accepted overpayment files without verifying the accuracy of the results. Without independently confirming overpayment results of the agreed-upon procedures audits, IVC is at risk of not recovering all program overpayments.

Finding 1 Conclusion

VHA made accurate payments on approximately 33.1 million of 33.6 million outpatient healthcare service transactions to Optum (98.6 percent) and on approximately 25 million of 25.1 million outpatient healthcare service transactions (99.8 percent) to TriWest. VHA, TPAs, and community providers generally met the CCN contracts' required timeliness metrics for all five regions. However, VHA made payment-rate errors on approximately 459,000 of 33.6 million outpatient healthcare service transactions for payments made to Optum and on approximately 56,200 of 25.1 million outpatient healthcare service transactions to TriWest. While the error rates were low, they resulted in estimated overpayments of about $105.1 million to Optum and $73.4 million to TriWest. Better oversight could reduce the risk of these overpayments. For example, VHA's Community Care Reimbursement System does not have business rules to validate the fee schedule used or reimbursement rate for claims submitted by

[43] When overpayment files are not accepted because of a sequencing issue, they are rejected and then sent back to the TPA. A sequencing issue occurred when the adjusted claim was not yet received by IVC to confirm the accuracy of the overpayment file.

[44] According to IVC, region 3 began these audits in FY 2020, quarter 2. IVC had granted Optum an extension for the remaining seven files to allow the adjusted claims to become available for review.

[45] Region 4 began agreed-upon procedures audits in FY 2020, quarter 4, and region 5 began them in FY 2022, quarter 1. According to IVC's Internal Review and Oversight, it is working to request two outstanding overpayment files for FY 2021 from TriWest; the five remaining files for FY 2023 are not yet completed by TriWest. IVC will still need to complete the remaining recoveries from FY 2022 (for Optum) and FY 2023 (for TriWest).

TPAs. As a result, VHA relied on the TPAs to process provider claims and seek reimbursement from VHA at the correct contracted rate. In addition, VHA did not establish payment controls in the contract to limit reimbursements to a percentage of the billed charges for services that are not on the Medicare or VA fee schedule. Finally, during this audit, CCN contract CORs were not responsible for reviewing healthcare claims for accuracy.

VHA has made some overpayment recoveries through the agreed-upon procedures audits but still needs to complete the remaining recoveries from FY 2020 through FY 2022 (Optum) and FY 2020 through FY 2023 (TriWest) forward. In addition, IVC's overpayment recoveries are significantly less than OIG estimates.

Recommendations 1–3

The OIG recommended the under secretary for health take the following actions:

1. Make sure the Office of Integrated Veteran Care develops contract language and/or maximum allowable rates to limit reimbursements that do not have a Medicare or VA fee schedule rate for Community Care Network claims.
2. Ensure the Office of Integrated Veteran Care improves oversight of healthcare claim payments to prevent, identify, and recover overpayments in a more timely manner.

The OIG recommended the under secretary for health, in conjunction with the chief acquisition officer and principal executive director for the Office of Acquisition, Logistics, and Construction, take the following action:[46]

3. Ensure the Office of Integrated Veteran Care and the Office of Acquisition, Logistics, and Construction, collaborate to extend the contracting officer's representatives' designated responsibilities to include monitoring of healthcare invoices.

VA Management Comments

VHA's under secretary for health concurred with the first two recommendations, concurred in principle with the third, and provided an action plan for each.[47] The acting principal director of the Office of Acquisition, Logistics, and Construction (also serving as acting chief acquisition officer) concurred in principle with recommendation three and agreed to follow VHA's action

[46] One person serves in both these roles.

[47] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 17, 2024.

plan for the recommendation. See appendixes D and E for the full responses from the under secretary and the Office of Acquisition, Logistics, and Construction.

For recommendation 1, IVC created maximum allowable rates to be used when Medicare rates are not available. In addition, it will develop contract language that clearly defines reimbursement limits when Medicare and VA fee schedules do not apply. IVC will assess processes related to external audit deliverables to accelerate recoveries of overpayments from the TPA and will expand the post payment review process to better monitor overpayment recoveries to address recommendation 2. For recommendation 3, IVC is working with the Strategic Acquisition Center to review and revise the COR nominations and delegations for the CCN program, as well as COR roles and responsibilities, in an effort to improve oversight.

OIG Response

The VHA under secretary for health provided acceptable action plans for the three recommendations. The OIG will monitor progress and close the recommendations when adequate documentation has been provided to demonstrate sufficient implementation steps have been taken.

Finding 2: Improved Oversight of Community Care Network Contracts Is Needed to Limit Unwarranted Dental Reimbursements to TPAs

The OIG estimated that from FY 2020 through May 2024, VHA paid Optum approximately $783.4 million more than Optum paid community providers for dental services, and VHA paid TriWest approximately $127.3 million more than TriWest paid providers for dental services. This occurred because dental service invoices were not processed as a pass-through like many other healthcare invoices, due to the absence of language specific to dental pass-throughs in the CCN region 1–4 contracts.

The finding is based on the following determinations:

- Contracts for regions 1 through 4 do not prevent TPAs from collecting more from VHA than TPAs pay providers.
- Ineffective oversight of the contract modification process resulted in excessive dental reimbursements.

What the OIG Did

The OIG team conducted site visits to IVC's Integrated External Networks office in Denver, Colorado, and the Strategic Acquisition Center in Fredericksburg, Virginia. The audit team interviewed VHA program officials responsible for the administration of the CCN program as well as Optum officials.

The team reviewed CCN dental payments made using the Community Care Reimbursement System from the beginning of FY 2020 through May 2024. The team reviewed the complete universe of payments for this period for pricing errors based on the contract-negotiated rates for the Optum and TriWest contracts. The team also calculated pass-through excess, where VHA paid more to each TPA than the TPA paid community dental providers.

Contracts for Regions 1 Through 4 Do Not Prevent TPAs from Collecting More from VHA Than TPAs Pay Providers

According to the contract, in addition to the TPA being reimbursed for payments to dental providers, the TPAs are paid a fee under a "per member per month" model for all administrative services for managing the dental services purchased under the CCN contracts.[48]

[48] The per member per month charge is invoiced in accordance with the total number of active veterans per month. The per member per month payment model is tiered to accommodate for low volumes but to also reduce as volumes increase. As volume progresses to the next tier, the per member per month price for the next tier shall be applied for the next group of active veterans.

The reimbursement process described in the CCN region 1–4 contracts states only that VHA will reimburse TPAs for dental services at the rate negotiated and identified in the contract. It does not include any pass-through language requiring the TPAs to seek reimbursement for the actual amount they paid community providers up to the negotiated contract rates. This means that a TPA could negotiate a rate with a provider that is less than the negotiated rate at which the TPA will be reimbursed by VA. Without a pass-through limitation, the TPA can seek reimbursement from VA at the higher contract rate and keep the difference. Example 3 illustrates the situation.

Example 3

Optum paid a provider $1,056.24 for dental services and then sought reimbursement and was reimbursed $2,024.13 by VHA at the contracted rate. This resulted in a difference of $967.89 that was paid to Optum for the dental services that was not passed through to the provider. This excess payment is in addition to the administrative fee that would be paid to Optum under the per member per month model.

The region 5 contract, however, does include pass-through language limiting the reimbursement amount TriWest can seek from VHA to the amount the provider was paid by TriWest or the contracted rate, whichever was less.

The OIG estimated that the absence of such language for the regions 1–3 contracts resulted in VHA reimbursing Optum approximately $783.4 million more than Optum paid providers from FY 2020 through May 2024. According to VHA-provided data, Optum was also paid approximately $42 million under the per member per month model for managing the administrative dental services from FY 2021 through FY 2023. Figure 8 (on the next page) breaks down the total excess amount VHA paid Optum by region for dental services beyond what Optum paid providers for regions 1–3.

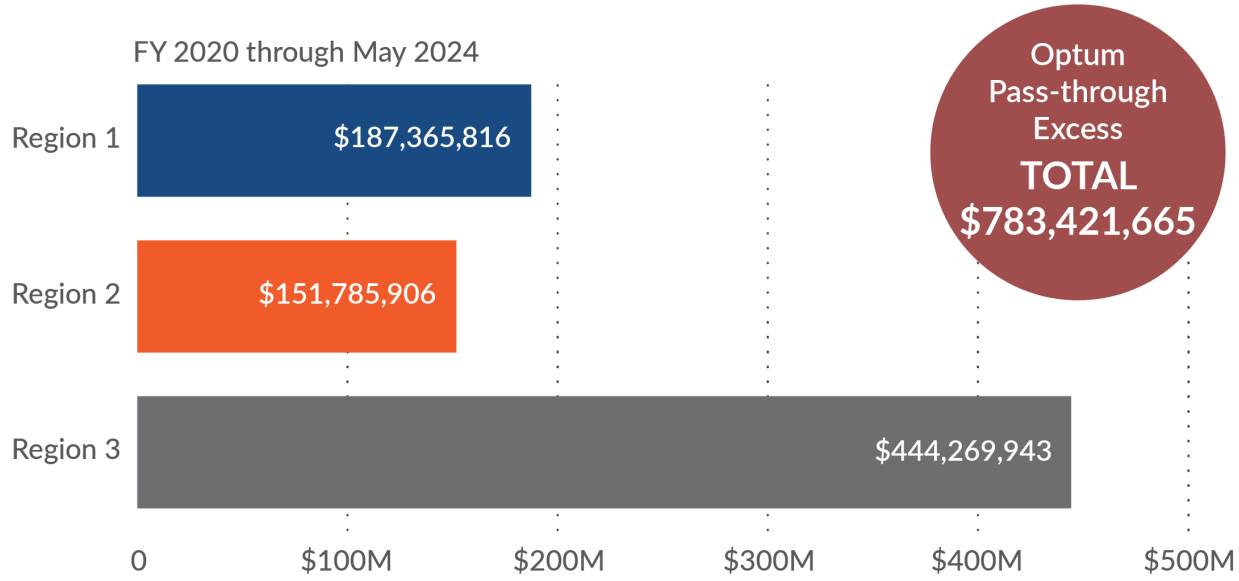

Figure 8. *Dental pass-through excess for Optum, FY 2020 through May 2024 by region.*

Source: VA OIG analysis of Community Care Reimbursement System dental payment data from the Corporate Data Warehouse for regions 1–3 from FY 2020 through May 2024.

The OIG estimated the absence of pass-through language in the contract resulted in VHA paying TriWest approximately $127.3 million more than TriWest paid providers in regions 4 and 5 from FY 2020 through May 2024. For region 4, TriWest was also paid approximately $13 million under the per member per month model for managing the administrative dental services from FY 2021 through FY 2023. Figure 9 identifies the total excess amount VHA paid TriWest by region for dental services.

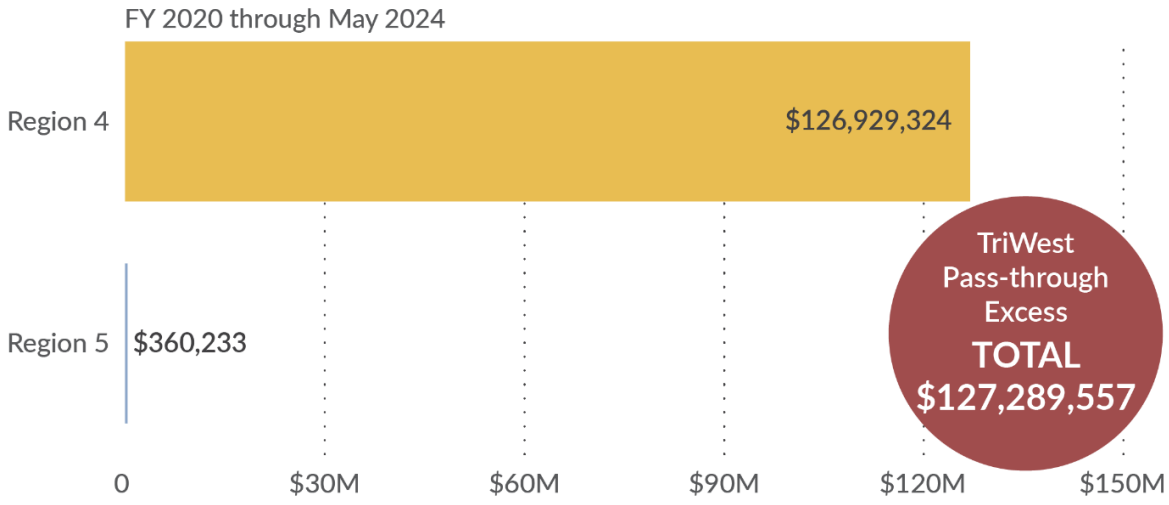

Figure 9. *Dental pass-through excess for TriWest, FY 2020 through May 2024 by region.*

Source: VA OIG analysis of Community Care Reimbursement System dental payment data from the Corporate Data Warehouse for regions 4–5 from FY 2020 (quarter 1) through May 2024.

The OIG estimated these pass-through excesses cost VHA $910.7 million of about $2.4 billion in program expenditures for dental services (37.3 percent) for the CCN region 1–4 contracts. Figure 10 identifies the percentage of total dental spending that was paid to each TPA as pass-through excess.

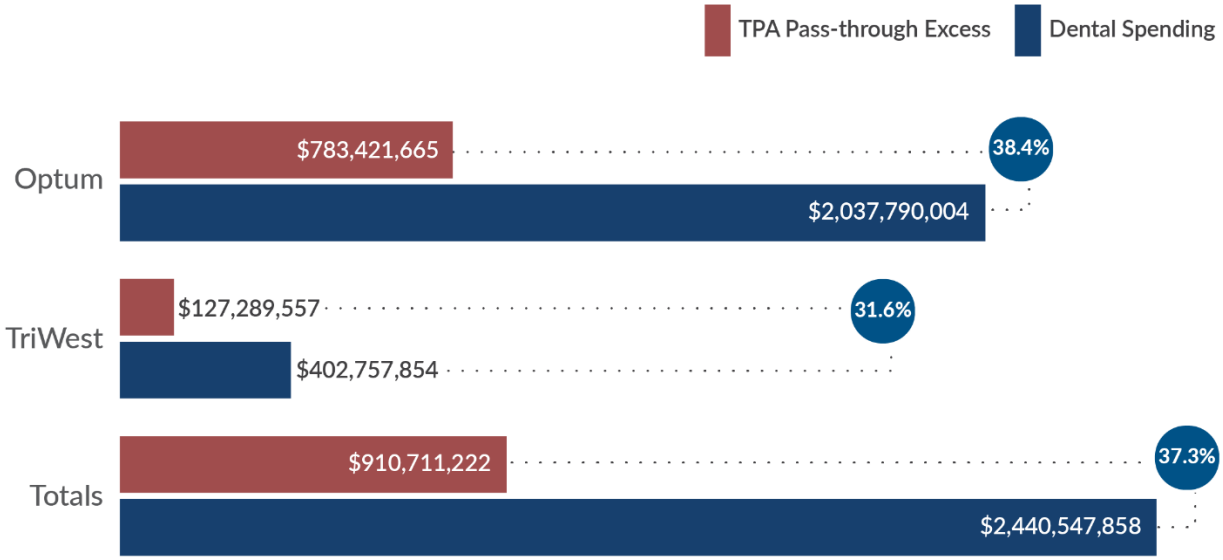

Figure 10. *Percentage of total dental spending paid to each TPA as pass-through excess, FY 2020 through May 2024.*

Source: VA OIG analysis of Community Care Reimbursement System dental payment data from the Corporate Data Warehouse for Optum and TriWest (regions 1–5) from FY 2020 through May 2024.

IVC has been aware of the lack of "pass-through" language in the contracts for regions 1–4 for several years. According to VHA meeting minutes, as of October 2021, Integrated External Networks personnel became aware the TPAs had been paid approximately $46 million more than they paid providers for dental services. As a result, the Integrated External Networks COR invoicing team asked the Strategic Acquisition Center in October 2021 for an interpretation of the contract language. A Strategic Acquisition Center contracting officer responded, stating dental services were considered a pass-through across all five regions and an administrative modification was needed to update contracts 1–4. The response also recommended that Integrated External Networks confirm the payment methodology to ensure this was how VA intended for dental services to be reimbursed.

Additional discussions followed with Integrated External Networks leaders, but IVC did not take further action until July 2023 when an Integrated External Networks official told the OIG team that IVC was discussing a potential contract modification that would make dental services a pass-through and prohibit the TPAs from seeking reimbursement from VHA for more than TPAs pay providers. Since July 2023, the Strategic Acquisition Center and IVC have been negotiating contract modifications with the TPAs for the region 1–4 contracts. According to a Strategic Acquisition Center contracting officer, as of August 2024, the modification is still under negotiation with each TPA.

Ineffective Oversight of the Contract Modification Process Resulted in Excessive Dental Reimbursements to Optum

VHA reimbursed Optum for more than the original contracted rate for many dental services, resulting in approximately $648.7 million in payments exceeding the previously established contracted rate. This occurred because Strategic Acquisition Center contracting officers made an error and accepted a proposal to increase pricing for the contracts' entire dental fee schedule instead of only for the new dental services. This contract modification error resulted in the approximately $648.7 million of the $783.4 million, identified above, that VHA paid Optum that was greater than what was paid to CCN region 1–3 community dental providers.

The contracted rate for dental services for CCN regions 1–3 was negotiated and established in the base contracts. The Strategic Acquisition Center worked with Optum periodically to negotiate pricing for new dental codes to be added to the existing base contract rate schedules. In March 2021, prior to the completion of the update for new dental codes, Optum submitted a memorandum with the VHA reasonable charges dental schedule, which included rates for existing contract codes as well as rates for new codes not initially included in the contract. Despite the contracting personnel's original intent to issue a modification to only establish rates for new dental procedure codes, the Strategic Acquisition Center mistakenly included the VHA reasonable charges dental schedule rates for existing codes. The updated rates for existing codes were, on average, approximately 66 percent higher than the original contracted rates that should have been used. Table 1 identifies the total dollar impact of the modification error for regions 1–3 on the contract expenditures for dental services.

Table 1. Dollar Effect of Dental Modification for Optum, June 2021–May 2024 by Region and Quarter

Region	FY 2021	FY 2022	FY 2023	FY 2024	Totals
1	$4,973,784	$44,848,391	$64,781,717	$50,025,574	$164,629,465
2	$3,176,819	$31,781,611	$50,301,462	$36,629,049	$121,888,941
3	$9,218,275	$95,706,073	$145,790,477	$111,429,614	$362,144,440
Totals	**$17,368,878**	**$172,336,075**	**$260,873,656**	**$198,084,237**	**$648,662,846**

Source: VA OIG analysis of contract documentation and Community Care Reimbursement System dental payment data from the Corporate Data Warehouse for Optum regions 1–3 from June 2021 through May 2024.

The modifications the contracting officer signed and returned to Optum only included language discussing the new codes and contained no discussion of updating all codes. Further, the independent government cost estimate performed during the modification process also only

included analysis to establish pricing for the new codes.[49] The modification language did not discuss increasing the existing contracted dental rates. When the audit team asked the Strategic Acquisition Center about the modifications to existing dental codes, the contracting officer confirmed that the modification should have applied only to new dental codes and the reasonable charges schedule for the existing codes should not have been included.

According to Strategic Acquisition Center contracting staff, they were not aware that the contracts' existing contracted dental rates had increased before being informed by the OIG team. Upon review of the modification document with the team, Strategic Acquisition Center contracting officers acknowledged they mistakenly accepted the TPA's new dental rates by incorporating Optum's fee schedule proposal for new dental procedures with the modification. In May 2023, the Strategic Acquisition Center executed a contract modification that returned the dental rates for existing codes to the original contracted dental rates; however, Optum continues to seek and be reimbursed at the increased rates. As of August 2024, the Strategic Acquisition Center was working with Integrated External Networks to quantify the impact of the dental modification and pursue any recovery of funds.

Finding 2 Conclusion

VHA paid Optum approximately $783.4 million more and TriWest about $127.3 million more than the TPAs paid community dental providers for services provided from FY 2020 through May 2024. This occurred because dental services invoices for regions 1–4 were not processed as a pass-through like many other healthcare invoices, including dental services in region 5. In addition, about $648.7 million of the $783.4 million excess reimbursement to Optum was due to an error made by Strategic Acquisition Center contracting officers during the contract modification process.

Recommendations 4–7

The OIG recommended the under secretary for health take the following action:

4. Make sure the Office of Integrated Veteran Care considers including dental contract reimbursement language in the current and/or future contracts that is consistent with other contract healthcare reimbursement methodology to limit dental contract reimbursements, not to exceed the amount the third-party administrators pay the providers.

[49] An independent government cost estimate is the anticipated cost of a proposed acquisition and provides a baseline for determining the fairness and reasonableness of a contractor's proposed price.

The OIG recommended the chief acquisition officer and principal executive director for the Office of Acquisition, Logistics, and Construction take the following action:[50]

5. Make certain the Office of Procurement, Acquisition, and Logistics develops sufficient oversight and internal controls over the contract modification process to prevent program overpayments.

The OIG recommended the under secretary for health, in conjunction with the chief acquisition officer and principal executive director for the Office of Acquisition, Logistics, and Construction, take the following actions:

6. Require the Office of Veteran Integrated Care and the Office of Acquisition, Logistics, and Construction to collaborate to explore potential recovery of dental payments to Optum.
7. Ensure the Office of Integrated Veteran Care and the Office of Acquisition, Logistics, and Construction collaborate to establish oversight and internal controls for dental services provided through Community Care Network to prevent excessive reimbursements.

VA Management Comments

The under secretary for health concurred with recommendations 4, 6, and 7 and provided action plans for each.[51] The acting principal director of the Office of Acquisition, Logistics, and Construction (also serving as acting chief acquisition officer) concurred with recommendations 5, 6, and 7 and agreed to follow VHA's action plans. See appendixes D and E for the full responses from the under secretary and the Office of Acquisition, Logistics, and Construction.

IVC will explore adding additional dental reimbursement language within the current and future CCN contracts for recommendation 4. To address recommendation 5, IVC and the Office of Acquisition, Logistics, and Construction will review lessons learned and make efficiency modifications to the preaward and postaward processes to reduce errors. For recommendation 6, IVC will support the Office of Acquisition, Logistics, and Construction concerning modifications to the process of recovering overpayments. Subject matter experts from both offices will coordinate with VHA Enterprise Risk Management to explore opportunities for further oversight regarding CCN dental reimbursements for recommendation 7.

[50] One person serves in both these roles.

[51] VA's responses and comments to this report were provided by individuals in leadership positions at the time of the department's formal review—December 17, 2024.

OIG Response

The VHA under secretary for health provided acceptable action plans for the four recommendations. The OIG will monitor progress and close the recommendations when adequate documentation has been provided to demonstrate sufficient implementation steps have been taken.

Appendix A: Scope and Methodology

Scopes

The audit team conducted its work from January 2023 through November 2024. The team sampled Community Care Network (CCN) outpatient professional community care claims paid to Optum since the beginning of healthcare delivery, from approximately fiscal year (FY) 2020 (beginning October 2019) through FY 2022, and paid to TriWest from FY 2020 through FY 2023.[52]

The audit team performed its audit work to determine the accuracy of payments for CCN healthcare claims paid to Optum for CCN regions 1–3 and TriWest for regions 4–5. Figure A.1 shows a map of the regions and third-party administrators (TPAs).

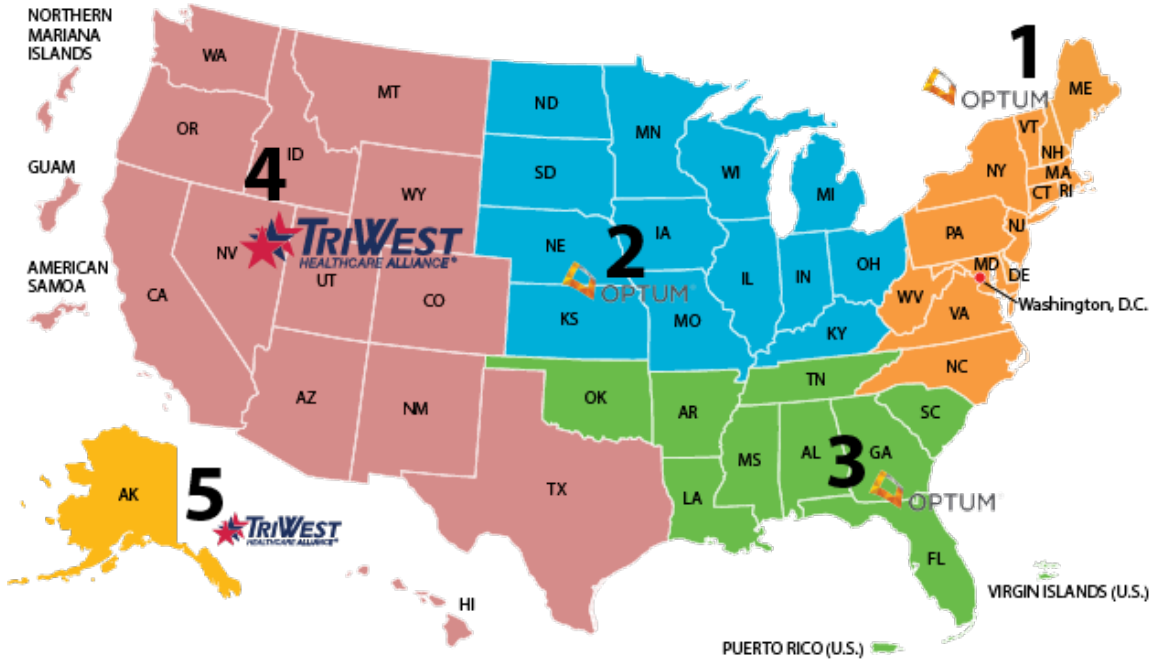

Figure A.1. *Five regional networks that compose VA's Community Care Network.*
Source: VA.gov.

The audit included a universe of approximately 33.6 million outpatient healthcare transactions estimated at $5.2 billion processed from approximately October 2019 (FY 2020) through September 2022 (FY 2022) for Optum and a universe of approximately 25.1 million outpatient healthcare transactions estimated at $4.5 billion processed from approximately October 2019 (FY 2020) through September 2023 (FY 2023) for TriWest.

[52] The original audit universe was Optum from FY 2020 through FY 2022; TriWest from FY 2020 through FY 2023 was added.

The audit team also reviewed transactions paid on or after October 1, 2019, and by May 31, 2024, for dental transactions from both TPAs.

Methodology

The audit team reviewed applicable laws, regulations, policies, procedures, guidelines, and contracts governing the CCN program. The audit team interviewed officials from the Office of Integrated Veteran Care (IVC), the Strategic Acquisition Center, and Optum. The team consulted with the VA Office of Inspector General (OIG) statistician and obtained 800 transactions each from Optum and TriWest to review claim payment accuracy and timeliness.[53]

To review payment accuracy, transactions were priced against the payment.[54]

The team reviewed the sample to determine the following:

- Payments were made at a rate greater than the applicable contract-allowed amount for the payment schedule under which the claim was paid.
- Payments were made using the correct payment hierarchy (first the Medicare fee schedule rates; then, if no Medicare rate is available, the local VA fee schedule rate; followed by reimbursement at a percentage of billed charges if no Medicare or VA fee schedule rate is available).
- VHA paid the TPAs more than they paid the network provider (pass-through excess). (For example, Optum pays a provider $80 and submits a claim for reimbursement to VHA for $100, resulting in a $20 overpayment to Optum.)
- Claims were paid within the contract's allowable time period.
    - Provider must file claims within 180 days to TPAs.
    - TPA must pay the provider within 30 days of the receipt of the claim.
    - VHA must pay TPAs within 14 days of receipt of the claim.

Internal Controls

The audit team assessed the internal controls of IVC's Office of Internal Review and Oversight as they relate to the CCN payments. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.[55] In addition, the team reviewed the principles of internal

[53] The audit sample included 800 line-item transactions processed from Optum and 800 line-item transactions processed from TriWest.

[54] A claim can have one or more transactions. Claim-level payments include all transactions on a claim.

[55] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

controls as associated with the objective. The team identified three components and six principles as significant to the objective and proposed recommendations to address the following control deficiencies:[56]

- Component 1: Control Environment
    - Principle 2: The oversight body should oversee the entity's internal control system.
    - Principle 3: Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.
- Component 3: Control Activities
    - Principle 10: Management should design control activities to achieve objectives and respond to risks.
    - Principle 12: Management should implement control activities through policy.
- Component 5: Monitoring
    - Principle 16: Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.
    - Principle 17: Management should remediate identified internal control deficiencies on a timely basis.

Data Reliability

The OIG's Office of Data and Analytics provided the audit team with Community Care Reimbursement System data. The audit team performed the data reliability steps detailed in the next paragraph for all transactions in the statistical sample.

To assess the data reliability of all Community Care Reimbursement statistically selected sample items, the audit team performed a validation of data against provider claims and remittance advices for claim and patient identification, dates of service, and procedure codes. The audit team additionally tested the claim totals of the sample data against Financial Management System claim totals and conducted reasonableness testing. The OIG concluded the data were valid and sufficiently reliable to support the audit's objectives and conclusions.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain

[56] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

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 B: Statistical Sampling Methodology

Approach

The VA Office of Inspector General (OIG) conducted this audit to determine the accuracy and timeliness of outpatient healthcare services payments for veteran patients receiving care via the Community Care Network (CCN). The audit included transactions that were paid from fiscal year (FY) 2020 through FY 2022 for Optum outpatient and dental services in CCN regions 1–3 and paid from July 2020 through FY 2023 for TriWest outpatient and dental services in CCN regions 4–5. All transactions were processed in VA's Community Care Reimbursement System.

Populations

Optum: The audit team identified 35,035,834 claim lines VA paid Optum for CCN regions 1–3, totaling $5,860,071,713 from FYs 2020 through 2022.

TriWest: The audit team identified 26,181,342 claim lines VA paid TriWest for CCN regions 4–5, totaling $4,754,859,542 from FY 2020 through FY 2023.

Dental claims: Dental claims were sampled from the respective Optum and TriWest populations for the purpose of measuring timeliness of payments. The audit team performed a 100 percent review of all dental claims for the overall review period and both third-party administrators (TPAs). The audit team reviewed 1,974,559 dental claims for which VA paid $2,440,547,858 to both TPAs for CCN regions 1–5 from FY 2020 through May 2024.

Sampling Design

The audit team reviewed two different populations reflecting two different scope periods that were all paid between October 2019 and September 2023. Paid Optum transactions were stratified by contract line item number (CLIN) and dollar amount grouping. Samples were selected randomly per stratum for a total of 800 samples representing 797 distinct claims. Paid TriWest transactions were also stratified by CLIN and dollar amount grouping. Samples were selected in probability proportion to size based on paid amount within each stratum for a total of 800 samples representing 800 unique claims.

Tables B.1 and B.2 present the stratified sample populations for the Optum and TriWest populations.

Table B.1. Stratified Sample for Optum

CLIN	Strata	Payment amount grouping	Number of samples	Total transactions	Total paid
10	1	≥ $1,000	25	262,814	$423,992,357.88
10	2	≥ $250 < $1,000	50	401,181	$171,757,561.50
10	3	≥ $75 < $250	50	635,019	$89,876,261.20
10	4	≥ $25 < $75	50	174,895	$11,608,594.40
10	5	Top 25	25	25	$1,162,871.43
1	1	≥ $10,000	25	13,387	$183,726,405.38
1	2	≥ $1,000 < $10,000	50	337,131	$716,239,549.18
1	3	≥ $250 < $1,000	50	1,560,543	$693,692,370.88
1	4	≥ $50 < $250	50	21,428,882	$2,283,821,803.00
1	5	Top 25	25	25	$1,716,439.33
6	1	≥ $10,000	25	178	$2,881,344.58
6	2	≥ $1,000 < $10,000	50	24,639	$47,426,396.20
6	3	≥ $250 < $1,000	50	406,806	$161,786,618.29
6	4	≥ $50 < $250	50	9,406,505	$942,397,062.00
6	5	Top 25	25	25	$1,367,521.75
7	1	≥ $10,000	25	1,395	$31,811,679.05
7	2	≥ $1,000 < $10,000	50	13,755	$40,203,554.30
7	3	≥ $250 < $1,000	50	42,851	$19,033,855.30
7	4	≥ $50 < $250	50	325,753	$32,254,913.50
7	5	Top 25	25	25	$3,314,553.41

Source: VA OIG's population includes dental. Community Care Reimbursement System payment data were from the Program Integrity Tool for CCN regions 1–3 (Optum) from FY 2020 (quarter 1) through FY 2022 (quarter 4). Optum samples were selected with stratified random sampling.

Table B.2. Stratified Sample for TriWest

CLIN	Strata	Payment amount grouping	Number of samples	Total transactions	Total paid
1	1	≥ $10,000	50	12,862	$193,728,960.57
1	2	≥ $1,000 < $10,000	50	287,323	$621,711,172.39
1	3	≥ $250 < $1,000	50	1,298,430	$577,993,450.82
1	4	≥ $50 < $250	50	17,394,303	$1,881,331,242.63
10	1	≥ $1,000	50	47,437	$61,890,559.79
10	2	≥ $250 < $1,000	50	204,553	$141,470,657.42
10	3	≥ $75 < $250	50	561,084	$80,353,503.01
10	4	≥ $25 < $75	50	302,867	$14,905,512.88
6	1	≥ $10,000	50	366	$4,882,851.70
6	2	≥ $1,000 < $10,000	50	32,628	$71,843,742.86
6	3	≥ $250 < $1,000	50	971,622	$353,962,030.63
6	4	≥ $50 < $250	50	4,921,889	$638,376,600.16
7	1	≥ $10,000	50	2,219	$42,212,786.53
7	2	≥ $1,000 < $10,000	50	13,179	$46,352,574.58
7	3	≥ $250 < $1,000	50	27,336	$12,307,177.62
7	4	≥ $50 < $250	50	103,244	$11,536,718.05

Source: VA OIG's population includes dental. Payment data were from the Corporate Data Warehouse for regions 4–5 (TriWest) from FY 2020 (quarter 4) through FY 2023 (quarter 4). TriWest samples were selected in proportion to size based on paid amount within each stratum.

Table B.3 presents the sample populations reviewed for payment accuracy, and table B.4 presents the sample populations reviewed for timeliness.

Table B.3. Accuracy Transactions Sample by TPA

Scope	Description	Date range	Sample size (number of transactions)	Sample size (value of claims)	Total number of lines paid	Total amount of transactions payments
1	Optum (Regions 1–3)	Oct. 2019–Sept. 2022	600	$8,698,377	33,561,900	$5,161,674,066
2	TriWest (Regions 4–5)	Oct. 2019–Sept. 2023	600	$4,156,060	25,065,401	$4,456,239,309

Source: VA OIG's separate populations, excluding dental. Community Care Reimbursement System payment data were obtained from the Program Integrity Tool for CCN regions 1–3 (Optum) from FY 2020 (quarter 1) through FY 2022 (quarter 4). Payment data were obtained from the Corporate Data Warehouse for regions 4–5

(TriWest) from FY 2020 (quarter 4) through FY 2023 (quarter 4). Optum samples were selected with stratified random sampling. TriWest samples were selected in probability proportional to size based on paid amount within each stratum. Dental claims were excluded from this analysis as the entire dental population from CCN regions 1–5 from FY 2020 through May 2024 was identified and tested for accuracy.

Table B.4. Timeliness Claims Sample by TPA

Scope	Description	Date range	Sample size (number of unique claims)	Sample size (value of claims)	Total number of lines paid	Total amount of claims payments
1	Optum (Regions 1–3)	Oct. 2019–Sept. 2022	797	$9,944,809	35,035,834	$5,860,071,713
2	TriWest (Regions 4–5)	Oct. 2019–Sept. 2023	800	$4,273,091	26,181,342	$4,754,859,542

Source: VA OIG's separate populations, including dental. Community Care Reimbursement System payment data were obtained from the Program Integrity Tool for CCN regions 1–3 (Optum) from FY 2020 (quarter 1) through FY 2022 (quarter 4). Payment data were obtained from the Corporate Data Warehouse for regions 4–5 (TriWest) from FY 2020 (quarter 4) through FY 2023 (quarter 4). Optum samples were selected with stratified random sampling. TriWest samples were selected in proportion to size based on paid amount within each stratum.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

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 OIG statistician 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.

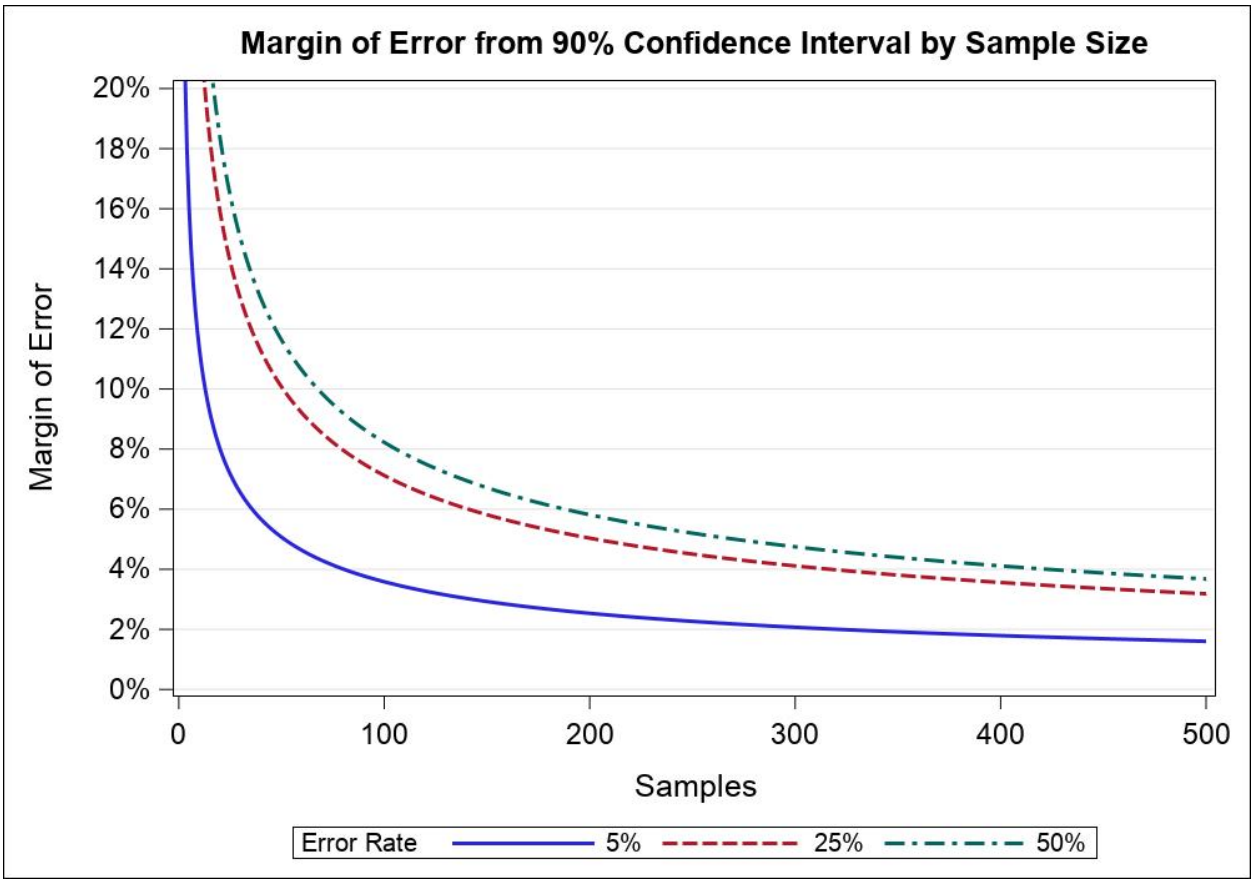

Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

Tables B.5 through B.10 present the OIG projections including the estimates derived from the sample populations including estimate of value or claims, margin of error, lower 90 percent value, and upper 90 percent value, sample size, and count.

Table B.5. Accuracy Dollar Estimates for Optum Population (total sample size = 600)

Estimate	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Amount paid in excess of Medicare rates	$57,548,240	$44,148,919	$13,399,321	$101,697,158	28
Amount paid in excess of VA's reasonable charges	$42,141,687	$7,168,728	$34,972,959	$49,310,414	65
Amount paid in excess of VA fee schedule rates	$5,363,338	$2,684,904	$2,678,434	$8,048,242	14

Estimate	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Total amount paid in excess of outpatient rates	**$105,053,264**	**$44,489,777**	**$60,563,488**	**$149,543,041**	**107**

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4).

Table B.6. Accuracy Transaction Estimates for Optum Population (total sample size = 600)

Estimate	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Total transactions paid in excess of outpatient rates	**458,868**	**434,877**	**23,992**	**893,745**	**107**

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4).

Table B.7 Timeliness Estimates for Optum Population (total sample size = 800)

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Provider submits claim to Optum average days	23.9	7.3	16.6	31.2	797
Optum to pay provider average days	9.7	1.4	8.3	11.1	797
VHA reimbursement to Optum average days	10.4	1.8	8.6	12.2	797
Provider submits claim to Optum on time	99.8	0.3	99.6	100.0	784
Optum to pay provider on time	97.8	2.7	95.1	100.0	764
VHA reimbursement to Optum on time	92.5	5.2	87.2	97.7	734

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Program Integrity Tool for Optum from FY 2020 (quarter 1) through FY 2022 (quarter 4).

Table B.8. Accuracy Dollar Estimates for TriWest Population (total sample size = 600)

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Amount paid in excess of Medicare rates	$43,731,649	$8,472,401	$35,259,248	$52,204,050	9
Amount paid in excess of VA's reasonable charges	$27,423,493	$6,301,670	$21,121,823	$33,725,162	62
Amount paid in excess of VA fee schedule rates	$2,241,204	$1,380,041	$861,163	$3,621,245	12
Total amount paid in excess of outpatient rates	**$73,396,346**	**$29,044,201**	**$44,352,145**	**$102,440,547**	**83**

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023 (quarter 4).

Table B.9. Accuracy Transaction Estimates for TriWest Population (total sample size = 600)

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Transactions paid in excess of Medicare rates	21,431	15,415	6,016	36,871	9
Transactions paid in excess of VA's reasonable charges	20,203	6,091	14,112	26,294	62
Transactions paid in excess of VA fee schedule rates	14,638	9,074	5,565	23,712	12
Total transactions paid in excess of outpatient rates	**56,172**	**18,783**	**37,389**	**74,938**	**83**

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023 (quarter 4).

Table B.10. Timeliness Estimates for TriWest Population (total sample size = 800)

Estimate name	Estimate number	90 percent confidence interval			Sample size
		Margin of error	Lower limit	Upper limit	
Provider submits claim to TriWest average days	24.6	4.6	20.0	29.2	782
TriWest to pay provider average days	2.6	0.5	2.1	3.0	786
VHA reimbursement to TriWest average days	7.6	0.3	7.3	7.9	789
Provider submits claim to TriWest on time	99.9	0.1	99.8	100.0	782
TriWest to pay provider on time	98.2	1.8	96.0	100.0	786
VHA reimbursement to TriWest on time	97.4	2.6	94.8	100.0	789

Source: VA OIG statistical projections based on a stratified sample of Community Care Reimbursement System payment data from the Corporate Data Warehouse for TriWest from FY 2020 (quarter 4) through FY 2023 (quarter 4).

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

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[57]
1	Establish controls to limit reimbursements that do not have a Medicare or VA fee schedule rate. (Optum $42,141,687 million and TriWest $27,423,493 million)	$69.6 million	—
2	Ensure VA identifies and recovers contract overpayments for Community Care Network contracts in a timely manner	—	$108.9 million
4–5	Ineffective oversight of the contract and modification process resulted in excessive dental reimbursements	$910.7 million	—
	Total	**$980.3 million**	**$108.9 million**

[57] The OIG questions costs when VA action or inaction (such as spending or failure to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit. Of the $108.9 million in questioned costs, $0 were unsupported costs.

Appendix D: VA Management Comments—Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: December 17, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services. (VIEWS 12401732)

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

1. Thank you for the opportunity to review and comment on OIG's draft report on Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services. The Veterans Health Administration (VHA) concurs with recommendations 1, 2, 4, 6, and 7. VHA concurs in principle with recommendation 3. Recommendation 5 belongs to the Office of Acquisition, Logistics, Construction.

2. VHA appreciates OIG's assistance in identifying an opportunity to provide accurate and timely payments to its Third-Party Administrators for the community care networks.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal, M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services

(OIG Project Number 2023-00748-AE-0025)

Recommendation 1: Make sure the Office of Integrated Veteran Care develops contract language and/or maximum allowable rates to limit reimbursements that do not have a Medicare or VA fee schedule rate for Community Care Network claims.

VHA Comments: Concur. The Office of Integrated Veteran Care (IVC) created maximum allowable rates to be used when Medicare rates are not available. The Department of Veterans Affairs (VA) rate setting utilizes industry benchmarks and scans for services not covered by Medicare or prior VA fee schedule services to ensure services have a maximum allowable and industry-based rate to the extent possible. IVC will develop proposed contract language that clearly defines reimbursement limits when Medicare and VA fee schedules do not apply.

Target Completion Date: December 2025

Recommendation 2: Ensure the Office of Integrated Veteran Care improve oversight of healthcare claim payments to prevent, identify, and recover overpayments in a more timely manner.

VHA Comments: Concur. IVC regularly collaborates with the Third-Party Administrator (TPA) on potential reimbursement/payment outliers. In addition to requiring proper pre-payment controls in the TPA adjudication system, each TPA is subject to external audits to scan for improper payments. Once found, the recoupment is made by the TPA, and the subsequent repayment is made to VA. IVC will assess processes related to external audit deliverables to accelerate recoupment from TPA, including a recoupment tracking mechanism. IVC will expand the post payment review process to flag unusual trends and develop a self-service reporting mechanism for reimbursement monitoring.

Target Completion Date: December 2025

Recommendation 3: Ensure the Office of Integrated Veteran Care and the Office of Acquisition, Logistics, and Construction, collaborate to extend the contracting officer's representatives' designated responsibilities to include monitoring of healthcare invoices.

VHA and Office of Acquisition, Logistics, and Construction (OALC) Comments: Concur in Principle. The Strategic Acquisition Center (SAC) in partnership with IVC is actively working to review and revise the Contracting Officer Representative (COR) nominations and delegations for the Community Care Network (CCN) program, along with the roles and responsibilities of the CORs to ensure better programmatic oversight. Additionally, SAC is assisting IVC with a possible request to the VA Revolving Funds Board of Directors of COR-specific billets for CCN.

Target Completion Date: December 2025

Recommendation 4: Make sure the Office of Integrated Veteran Care considers including dental contract reimbursement language in the current and/or future contracts that is consistent with

other contract healthcare reimbursement methodology to limit dental contract reimbursements, not to exceed the amount the third-party administrators pay the providers.

VHA Comments: Concur. IVC will explore incorporating additional dental reimbursement language within the current and future CCN contract. If action is deemed necessary, IVC will provide the proposed contract language for consideration.

Target Completion Date: December 2025

Recommendation 5: Make certain the Office of Procurement, Acquisition, and Logistics develops sufficient oversight and internal controls over the contract modification process to prevent program overpayments.

OALC Comments: Concur. OALC and IVC are reviewing lessons learned and implementing efficiencies to the modification process prior to award and after award to ensure future errors are less likely to occur.

Target Completion Date: December 2025

Recommendation 6: Require the Office of Integrated Veteran Care and the Office of Acquisition, Logistics, and Construction to collaborate to explore potential recovery of dental payments to Optum.

VHA and OALC Comments: Concur. IVC will partner with OALC to explore recovery. IVC will support OALC in any discussions and modifications as they continue to action recovery with Optum. IVC will request written updates from OALC on a quarterly basis.

Target Completion Date: December 2025

Recommendation 7: Ensure the Office of Integrated Veteran Care and the Office of Acquisition, Logistics, and Construction collaborate to establish oversight and internal controls for dental services provided through Community Care Network to prevent excessive reimbursements.

VHA and OALC Comments: Concur. Internal Control subject matter experts from both IVC and OALC, in coordination with VHA Enterprise Risk Management, will collaborate to explore further oversight opportunities related to the CCN dental reimbursements.

The documentation for this effort will be submitted through the annual internal control assessment by IVC to VHA as well as by OALC to VA. Any actions taken will include clear documentation of the internal control and associated responsibilities for monitoring and testing.

Target Completion Date: December 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.

Appendix E: VA Management Comments—Acting Principal Executive Director for the Office of Acquisition, Logistics, and Construction and Acting Chief Acquisition Officer

Department of Veterans Affairs Memorandum

Date: January 10, 2025

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

Subj: Office of Inspector General (OIG) Draft Report, Community Care Network Outpatient Claim Payments Mostly Followed Contract Rates and Timelines, but VA Overpaid for Dental Services - OIG Project Number 2023-00748-AE-0025 (VIEWS # 12408428)

To: Director, Office of Audits and Evaluations, (52A03)

1. The Office of Acquisition, Logistics, and Construction (OALC) reviewed the subject OIG Draft Report. OALC, in collaboration with the Veterans Health Administration (VHA), concurs with all findings and recommendations and will take the actions referenced in the VHA Action Plan.

The OIG removed point of contact information prior to publication.

(Original signed by)

Phillip W. Christy

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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