



Report to the Ranking Member of the
Committee on Veterans' Affairs, U.S.
Senate

September 2018

VETERANS CHOICE PROGRAM

Further Improvements Needed to Help Ensure Timely Payments to Community Providers

Accessible Version

GAO Highlights

Highlights of [GAO-18-671](#), a report to the Ranking Member of the Committee on Veterans' Affairs, United States Senate

Why GAO Did This Study

Questions have been raised about the lack of timeliness of TPAs' payments to community providers under the Choice Program and how this may affect the willingness of providers to participate in the program as well as in the forthcoming Veterans Community Care Program. You asked GAO to review issues related to the timeliness of TPAs' payments to community providers under the Choice Program.

This report examines, among other things, (1) the length of time TPAs have taken to pay community providers' claims and factors affecting timeliness of payments, and (2) actions taken by VA and the TPAs to reduce the length of time TPAs take to pay community providers for Choice Program claims.

GAO reviewed TPA data on the length of time taken to pay community provider claims from November 2014 through June 2018, the most recent data available at the time of GAO's review. GAO also reviewed documentation, such as the contracts between VA and its TPAs, and interviewed VA and TPA officials. In addition, GAO interviewed a non-generalizable sample of 15 community providers, selected based on their large Choice Program claims volume, to learn about their experiences with payment timeliness.

What GAO Recommends

GAO is making two recommendations, including that VA should collect data on and monitor compliance with its requirements pertaining to customer service for community providers. VA concurred with GAO's recommendations and described steps it will take to implement them.

View [GAO-18-671](#). For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

September 2018

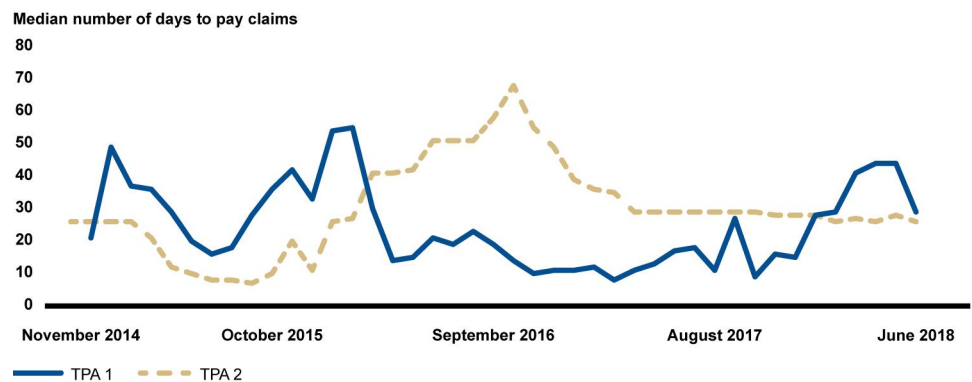
VETERANS CHOICE PROGRAM

Further Improvements Needed to Help Ensure Timely Payments to Community Providers

What GAO Found

The Department of Veterans Affairs' (VA) Veterans Choice Program (Choice Program) was created in 2014 to address problems with veterans' timely access to care at VA medical facilities. The Choice Program allows eligible veterans to obtain health care services from providers not directly employed by VA (community providers), who are then reimbursed for their services through one of the program's two third-party administrators (TPA). GAO's analysis of TPA data available for November 2014 through June 2018 shows that the length of time the TPAs took to pay community providers' clean claims each month varied widely—from 7 days to 68 days. VA and its TPAs identified several key factors affecting timeliness of payments to community providers under the Choice Program, including VA's untimely payments to TPAs, which in turn extended the length of time TPAs took to pay community providers' claims; and inadequate provider education on filing claims.

Median Number of Days to Pay Clean Claims through VA's Third Party Administrators (TPA), November 2014 through June 2018



Source: GAO analysis of TPA data. | GAO-18-671

VA has taken actions to address key factors that have contributed to the length of time TPAs have taken to pay community providers. For example, VA updated its payment system and related processes to pay TPAs more quickly. According to VA data, as of July 2018, VA was paying at least 90 percent of the TPAs' invoices within 7 days. In addition, VA and the TPAs have taken steps to improve provider education to help providers resolve claims processing issues. However, 9 of the 15 providers GAO interviewed said they continue to experience lengthy telephone hold times. According to VA and TPA officials, steps have been taken to improve the customer service offered to community providers. However, VA officials do not collect data on or monitor TPA compliance with customer service requirements—such as calls being answered within 30 seconds or less—for provider calls because they said they are not enforcing the requirements and are allowing TPAs to prioritize calls from veterans. Without collecting data and monitoring compliance, VA does not have information on challenges providers may face when contacting TPAs to resolve payment issues.

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Abbreviations

OIG	Office of Inspector General
RFP	request for proposals
SAR	secondary authorization request
TPA	third-party administrator
VA	Department of Veterans Affairs

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September 28, 2018

The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

Dear Senator Tester:

The Veterans Access, Choice, and Accountability Act of 2014 created the Veterans Choice Program (Choice Program) to address problems with veterans' timely access to care at Department of Veterans Affairs (VA) medical facilities.¹ Under the Choice Program, when eligible veterans face long wait times, lengthy travel distances, or other challenges accessing care at VA medical facilities, they may obtain health care services from community providers—that is, providers who are not directly employed by VA. The program is primarily administered by two contractors, known as third-party administrators (TPA)—TriWest Healthcare Alliance (TriWest) and Health Net Federal Services (Health Net)—which are responsible for, among other things, establishing nationwide networks of community providers, scheduling appointments for veterans, and paying community providers for their services.

Since its implementation, the Choice Program has faced challenges and drawn scrutiny. External reviews, media reports, and congressional hearings held over the course of the Choice Program's implementation and operation have highlighted several programmatic weaknesses. These weaknesses have included insufficient community provider networks, significant delays in scheduling appointments, and a lack of timely

¹Pub. L. No. 113-146, 128 Stat. 1754 (2014).

payments by the TPAs to community providers.² Media reports suggest that the untimely payments to community providers have created financial hardship for some and a reluctance to continue participating in the Choice Program.³ This has raised concerns that a reduction in participating community providers will increase wait times for veterans and result in longer travel distances, especially in rural areas. Due to these and other concerns, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.⁴

Congress recently passed legislation to help address some of the challenges faced by the Choice Program and VA's other community care programs.⁵ Specifically, the VA MISSION Act of 2018, signed into law in June 2018, requires VA to consolidate the Choice Program and its other VA community care programs into one community care program—the Veterans Community Care Program—in addition to authorizing VA to utilize a TPA for claims processing and requiring VA to reimburse

²See, for example, Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration: Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47 (Washington, D.C.: Dec. 21, 2017); Quil Lawrence, Eric Whitney, and Michael Tomsic, "Despite \$10B 'Fix,' Veterans Are Waiting Even Longer To See Doctors." *Morning Edition* (NPR, May 16, 2016) accessed January 27, 2017, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>; and Lee Romney, "Veterans Choice is Flawed, but Congress Is Stymied on a Solution," *The Center for Investigative Reporting*, (September 28, 2016, accessed January 27, 2017), <https://www.revealnews.org/article/veterans-choice-is-flawed-but-congress-is-stymied-on-a-solution>.

³See, for example, Stephanie Earls, "Veterans, Doctors Alike Stranded as Vet Choice Fails to Pay Its Bills," *The Gazette*, Mar. 17, 2018, accessed June 22, 2018, <https://gazette.com/health/veterans-doctors-alike-stranded-as-vet-choice-fails-to-pay-its-bills/article/1622450>; and Nick Ochsner, "Slow VA Choice Authorization, Reimbursements Frustrate Doctors' Offices" (Mar. 22, 2016), accessed July 10, 2018.

⁴GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

⁵The Choice Program is one of several VA programs that facilitate care for veterans from community providers. For more information about these VA community care programs, including differences in eligibility requirements and payment rates, see GAO, *Veterans' Health Care: Proper Plan Needed to Modernize System for Paying Community Providers*, [GAO-16-353](#) (Washington, D.C.: May 11, 2016).

community providers in a timely manner.⁶ Currently, VA is in the process of evaluating proposals for the Veterans Community Care Program. Under the current request for proposals (RFP) there will be an up to 1-year implementation period, and the new program is expected to begin serving veterans in fiscal year 2019. The Choice Program is expected to continue until that time and will statutorily sunset after June 6, 2019.

You asked us to review issues related to the timeliness of TPAs' payments to community providers under the Choice Program. In this report, we examine

1. the length of time TPAs have taken to pay community providers' claims under the Choice Program, VA's efforts to monitor these time frames, and factors that affected timeliness of payments, and
2. actions taken by VA and the TPAs to reduce the length of time TPAs take to pay community providers for Choice Program claims.

To examine the length of time TPAs have taken to pay community providers' claims under the Choice Program, factors affecting timeliness of payments, and VA's efforts to monitor these time frames, we reviewed TPA data on the length of time it took TPAs to pay claims and the number and percentage of claims rejected or denied over the course of the Choice Program, from November 2014 through June 2018, the most recent data available at the time of our review.⁷ To assess the reliability of these data, we collected information from TPA officials regarding the reliability of the data and reviewed the data for obvious errors and missing values. We discussed and worked with TPA officials to resolve any identified data issues. On the basis of these steps, we determined the claim payment data were sufficiently reliable for the purposes of our reporting objectives. However, data limitations prohibited us from assessing the extent to which the two TPAs rejected or denied claims. We also reviewed VA and TPA documentation, such as the contracts between VA and its TPAs, contract modifications, and VA's RFP for its

⁶Pub. L.No. 115-182, tit. I, 132 Stat. 182 (2018).

⁷According to TPA officials, rejected claims are claims returned up front to providers due to, for example, the use of invalid claim forms and missing provider identification numbers. Denied claims are claims that contain the necessary data elements but do not pass required claim processing steps, which, for example, verify the veteran's eligibility for the Choice Program and that a valid authorization for care is on file.

new contracts for the Veterans Community Care Program.⁸ We interviewed VA contracting officials and officials from the Office of Community Care (the office within VA's Veterans Health Administration responsible for implementing and overseeing the Choice Program) as well as TPA officials about VA's efforts to monitor TPA data on payment time frames, as well as claim rejections and denials, and factors that contributed to the length of time VA's TPAs have taken to pay providers. In addition, between April and June 2018, we interviewed a non-generalizable sample of 15 providers—including 7 that either currently participate or previously participated in the TriWest community provider network and 10 that either currently participate or previously participated in the Health Net community provider network—to identify any additional factors affecting payment time frames.⁹ We selected the providers with the largest Choice Program claims volume from July 2017 through December 2017, based on the most recent TPA data available at the time we selected these providers.

To examine the actions taken by VA and the TPAs to reduce the length of time TPAs take to pay community providers for Choice Program claims, we reviewed VA and TPA documentation, such as contract modifications and policy documents. We also interviewed VA contracting officials and Office of Community Care officials as well as TPA officials. In addition, we interviewed the 15 selected providers to determine how claim payment timeliness issues have affected them. We assessed the actions taken by VA and the TPAs to address the factors that contributed to the length of time taken to pay providers against federal standards for internal control for performing monitoring activities.¹⁰

We conducted this performance audit from February 2018 through September 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform our

⁸In December 2016, VA issued an RFP for contractors to help administer its new Veterans Community Care Program.

⁹Two of these providers participated in both the TriWest and Health Net provider networks. The providers we interviewed included hospital systems, group practices, and specialty providers, such as acupuncturists and chiropractors.

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999) and [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

work to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Veterans Access, Choice, and Accountability Act of 2014 provided up to \$10 billion in funding for veterans to obtain health care services from community providers through the Choice Program when veterans faced long wait times, lengthy travel distances, or other challenges accessing care at VA medical facilities.¹¹ The temporary authority and funding for the Choice Program was separate from other previously existing programs through which VA has the option to purchase care from community providers. Legislation enacted in August and December of 2017 and June 2018 provided an additional \$9.4 billion for the Veterans Choice Fund.¹² Authority of the Choice Program will sunset on June 6, 2019.¹³

Responsibilities of the Choice Program TPAs

In October 2014, VA modified its existing contracts with two TPAs that were administering another VA community care program—the Patient-Centered Community Care program—to add certain administrative responsibilities associated with the Choice Program. For the Choice Program, each of the two TPAs—Health Net and TriWest—are responsible for managing networks of community providers who deliver care in a specific multi-state region. (See fig. 1.) Specifically, the TPAs are responsible for establishing networks of community providers, scheduling appointments with community providers for eligible veterans,

¹¹Pub. L. No. 113-146, §§ 101, 802, 128 Stat. 1754, 1755-1765, 1802-1803 (2014).

¹²VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, § 101, 131 Stat. 958, 959 (Aug. 17, 2017) (providing an additional \$2.1 billion for the Veterans Choice Fund); Department of Homeland Security Blue Campaign Authorization Act of 2017, Pub. L. No. 115-96, Div. D, § 4001, 131 Stat. 2044, 2052-53 (Dec. 22, 2017) (providing an additional \$2.1 billion for the Veterans Choice Fund) and Pub. L. No. 115-182, tit. V, § 510, 132 Stat. 1392, ___ (2018) (providing an additional \$5.2 billion for the Veterans Choice Fund).

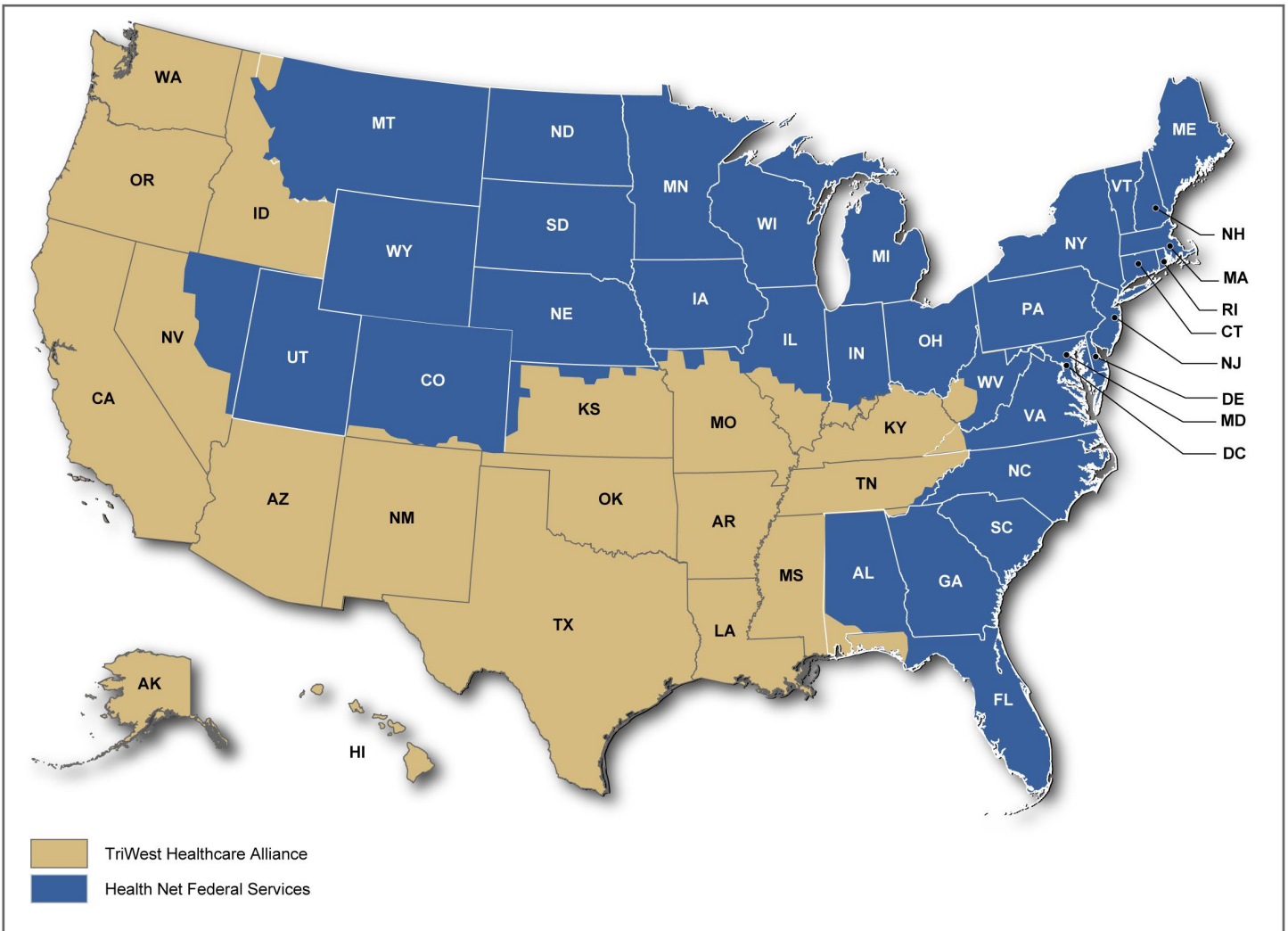
¹³Pub. L. No. 115-182, tit. I, § 143, 132 Stat. 1393, ___ (2018), amending section 101(p) of the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. at 1763.

and paying community providers for their services.¹⁴ Health Net's contract for administering the Choice Program will end on September 30, 2018, whereas TriWest will continue to administer the Choice Program until the program ends, which is expected to occur in fiscal year 2019.¹⁵

¹⁴Our previous work provides a detailed overview of VA's appointment scheduling process. See GAO, *Veterans Choice Program: Improvements Needed to Address Access-Related Challenges as VA Plans Consolidation of Its Community Care Programs*, [GAO-18-281](#) (Washington, D.C.: June 4, 2018).

¹⁵In July 2018, Health Net began transitioning responsibilities for scheduling appointments to VA. However, Health Net will be responsible for processing claims and paying providers for care delivered prior to this date.

Figure 1: Multi-state Regions Covered by the Veterans Choice Program’s Third Party Administrators (TPA)



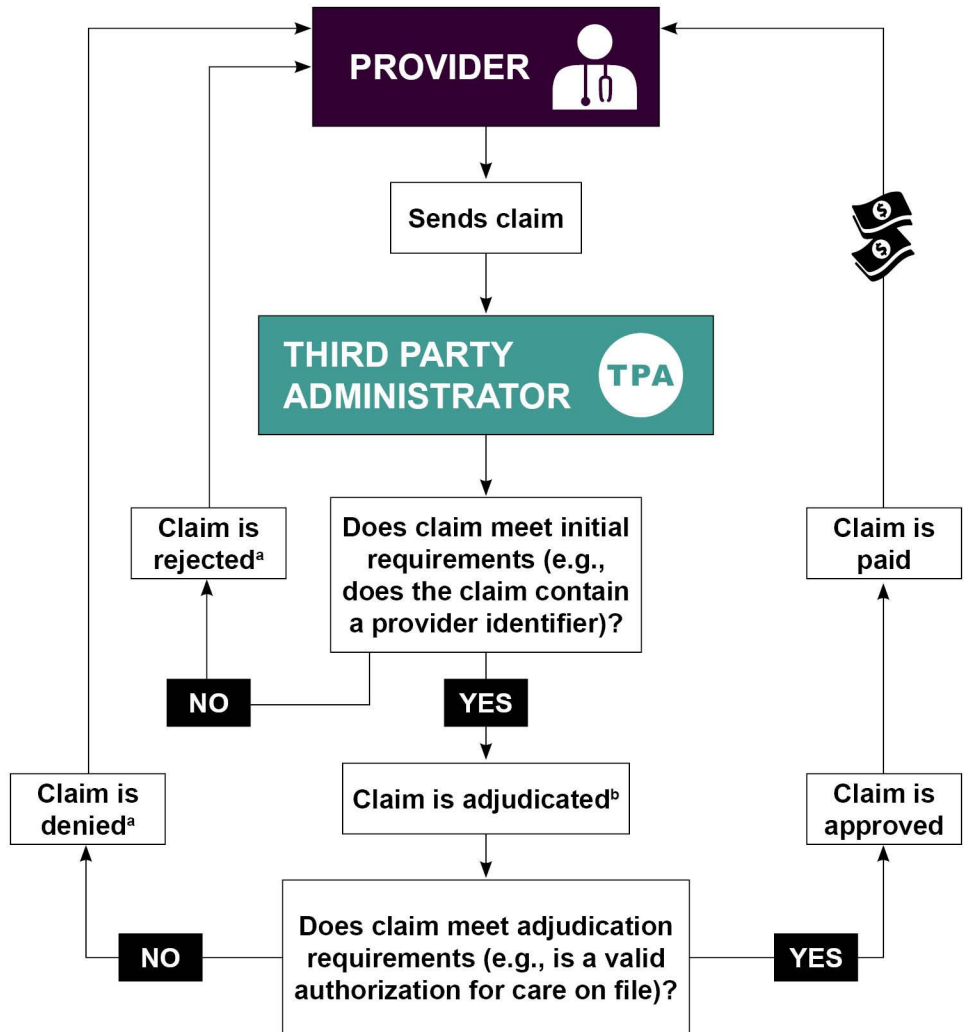
Sources: GAO illustration based on Department of Veterans Affairs information (data); Map Resources (map). | GAO-18-671

Note: TriWest Healthcare Alliance is the TPA for American Samoa, Guam, and the Northern Mariana Islands. Health Net Federal Services is the TPA for Puerto Rico and the U.S. Virgin Islands.

Choice Program Claim Processing and Payment

VA’s TPAs process claims they receive from community providers for the care they deliver to veterans and pay providers for approved claims. Figure 2 provides an overview of the steps the TPAs follow for processing claims and paying community providers.

Figure 2: Steps TPAs Follow to Process and Pay Claims from Community Providers for Care Delivered Under the Veterans Choice Program



Source: GAO analysis of third party administrator (TPA) information | GAO-18-671

^aAccording to TPA officials, rejected claims are claims returned up front to providers due to, for example, the use of invalid claim forms and missing provider identification numbers. Denied claims are claims that contain the necessary data elements but do not pass required claim processing steps, which, for example, verify the veteran’s eligibility for the Veterans Choice Program, that a valid authorization for care is on file, and that the claim is not a duplicate.

^bClaim adjudication refers to the process of reviewing a claim and making the decision to approve or deny it. Claims being adjudicated are either classified as clean or non-clean claims. Clean claims are claims that contain all required data elements, while non-clean claims are those claims that are missing required data elements that the TPA must obtain before the claim is paid.

VA's contracts with the TPAs do not include a payment timeliness requirement applicable to the payments TPAs make to community providers. Instead, a contract modification effective in March 2016 established a non-enforceable "goal" of processing—approving, rejecting or denying—and, if approved, paying clean claims within 30 days of receipt.

To be reimbursed for its payments to providers, the TPAs in turn submit electronic invoices—or requests for payment—to VA. TPAs generate an invoice for every claim they receive from community providers and pay. VA reviews the TPAs' invoices and either approves or rejects them. Invoices may be rejected, for example, if care provided was not authorized. Approved invoices are paid, whereas rejected invoices are returned to the TPAs. The federal Prompt Payment Act requires VA to pay its TPAs within 30 days of receipt of invoices that it approves.¹⁶

VA's Planned Consolidated Community Care Program

The VA MISSION Act of 2018, among other things, requires VA to consolidate its community care programs once the Choice Program sunsets 1 year after the passage of the Act, authorizes VA to utilize a TPA for claims processing, and requires VA to reimburse community providers in a timely manner. Specifically, the act requires VA (or its TPAs) to pay community providers within 30 days of receipt for clean claims submitted electronically and within 45 days of receipt for clean claims submitted on paper.

In December 2016, prior to enactment of the VA MISSION Act of 2018, VA issued an RFP for contractors to help administer the Veterans Community Care Program. The Veterans Community Care Program will be similar to the current Choice Program in certain respects. For example, VA is planning to award community care network contracts to TPAs, which would establish regional networks of community providers and process and pay those providers' claims. However, unlike under the Choice Program, under the Veterans Community Care Program, VA is planning to have medical facilities—not the TPAs—generally be responsible for scheduling veterans' appointments with community providers.

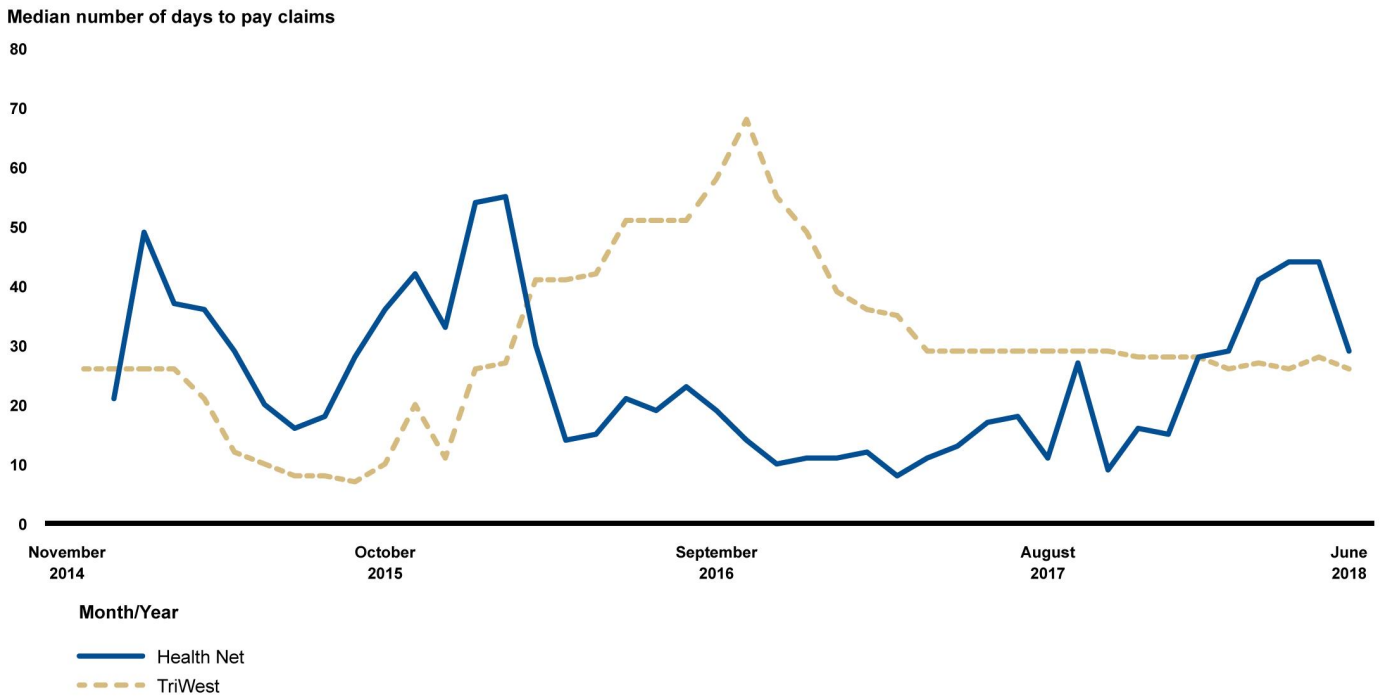
¹⁶31 U.S.C. § 3903(a)(1); 5 C.F.R. part 1315.

The Length of Time Taken by TPAs to Pay Claims from Community Providers Has Varied Widely, and VA's Monitoring of This Timeliness Has Been Limited

The Time TPAs Have Taken to Pay Claims Has Varied Widely, and Available Data Do Not Account for Payment Delays Due To Rejected or Denied Claims

From November 2014 through June 2018, VA's TPAs paid a total of about 16 million clean claims—which are claims that contain all required data elements—under the Choice Program, of which TriWest paid about 9.6 million claims and Health Net paid about 6.4 million. Data on the median number of days VA's TPAs have taken to pay clean claims each month show wide variation over the course of the Choice Program—from 7 days to 68 days. As discussed previously, in March 2016, VA established a non-enforceable goal for its TPAs to process and, if approved, pay clean claims within 30 days of receipt each month. Most recently, from January through June 2018, the median number of days taken to pay clean claims ranged from 26 to 28 days for TriWest, while it ranged from 28 to 44 days for Health Net. (See fig. 3.)

Figure 3: Median Number of Days to Pay Clean Claims through VA’s Third Party Administrators (TPA), November 2014 through June 2018

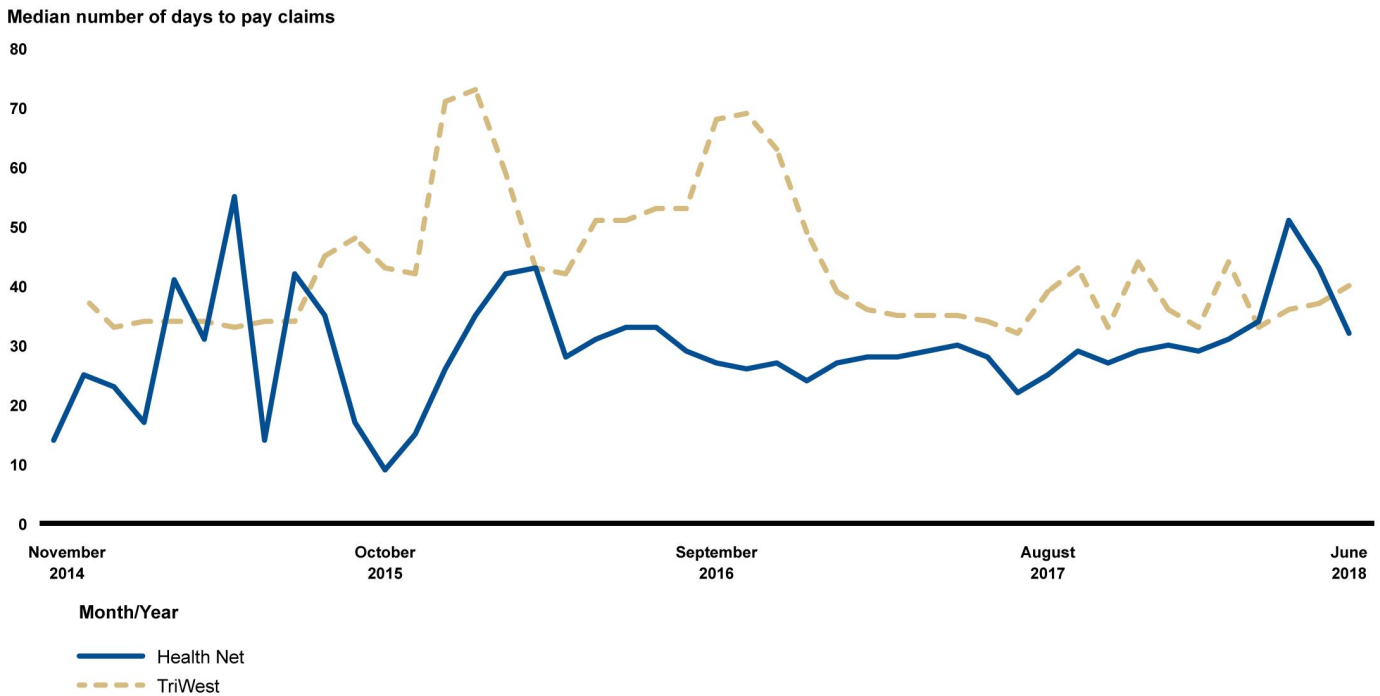


Source: GAO analysis of TPA data. | GAO-18-671

Note: The Department of Veterans Affairs (VA) established a goal for its TPAs to process and, if approved, pay clean claims within 30 calendar days of receipt. Clean claims are claims that contain all required data elements. Health Net did not pay any clean claims in November and December 2014 and TriWest did not pay any clean claims in November 2014.

In addition to the 16 million clean claims the TPAs paid from November 2014 through June 2018, during this time period they also paid approximately 650,000 claims (or 4 percent of all paid claims) that were classified as non-clean claims when first received after obtaining the required information. Non-clean claims are claims that are missing required information, which the TPA must obtain before the claim is paid. From November 2014 through June 2018, TriWest paid around 641,000 non-clean claims (or 6 percent of all paid claims) while Health Net paid about 9,600 non-clean claims (or less than 1 percent of all paid claims). Data on the median number of days VA’s TPAs have taken to pay non-clean claims each month also show wide variation over the course of the Choice Program—from 9 days to 73 days. (See fig. 4.)

Figure 4: Median Number of Days to Pay Non-Clean Claims through VA’s Third Party Administrators (TPA), November 2014 through June 2018



Source: GAO analysis of TPA data. | GAO-18-671

Note: Non-clean claims are claims that are missing required data elements that the Department of Veterans Affairs' (VA) TPA must obtain before the claim is paid. TriWest did not pay any non-clean claims in November 2014.

The data on the time TPAs have taken to pay approved clean and non-clean claims do not fully account for the length of time taken to pay providers whose claims are initially rejected or denied, as, according to the TPAs, providers are generally required to submit a new claim when the original claim is rejected or denied.¹⁷ Thus, providers that submit claims that are rejected or denied may experience a longer wait for payment for those claims or may not be paid at all. In some cases,

¹⁷According to TPA officials, rejected claims are claims returned up front to providers due to, for example, the use of invalid claim forms and missing provider identification numbers. Denied claims are claims that contain the necessary data elements but do not pass required claim processing steps, which, for example, verify the veteran’s eligibility for the Choice Program, that a valid authorization for care is on file, and that the claim is not a duplicate.

providers' claims may be rejected or denied multiple times after resubmission.¹⁸

Stakeholders Identified Three Key Factors Affecting the Timeliness of Claim Payments to Community Providers under the Choice Program

VA and its TPAs identified three key factors affecting the timeliness of claim payments to community providers under the Choice Program: (1) VA's untimely payments of TPA invoices; (2) Choice Program contractual requirements related to provider reimbursement; and (3) inadequate provider education on filing Choice Program claims, as discussed below.

VA's untimely payments of TPA invoices. According to VA and TPA officials, VA made untimely invoice payments to its TPAs—that is, payments made more than 30 days from the date VA received the TPAs' invoices—which resulted in the TPAs at times having insufficient funds available to pay community providers under the Choice Program.¹⁹ A VA Office of Inspector General (OIG) report estimated that from November 2014 through September 2016, 50 percent of VA's payments to its TPAs during this time frame were untimely.²⁰ VA officials stated that VA's untimely payments to the TPAs resulted from limitations in its fee-basis claims system, which VA used at the beginning of the Choice Program to process all TPA invoices.²¹ In addition, the VA OIG found that VA

¹⁸From November 2014 through June 2018, Health Net's data show that it denied about 29 percent of all claims community providers submitted to the Choice Program, with the denial rate having varied from month to month.

¹⁹TriWest officials attributed payment delays to VA's process for re-adjudicating community provider claims as part of its review of TPA invoices. This process resulted in invoice rejections, which the TPAs subsequently appealed. We cannot quantify the extent to which VA's untimely payments to the TPAs affected the length of time the TPAs' took to pay providers because we are unable to examine the impact of this factor in isolation from other factors impacting the time the TPAs took to pay providers.

²⁰See Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Audit of the Timeliness and Accuracy of Choice Payments Processed Through the Fee Basis Claims System*, Report No. 15-03036-47 (Washington, D.C.: Dec. 12, 2017). VA's OIG reviewed a sample of 646 paid claims for the two TPAs from November 1, 2014 through September 30, 2016.

²¹The fee-basis claims system was used nationwide by VA to process TPA invoices. After the TPAs adjudicated and paid community provider claims, they submitted invoices to VA. VA then used the fee basis claims system to re-adjudicate the original claim and determine whether the TPA's invoice for the claim should be paid.

underestimated the number of staff necessary to process Choice Program invoices in a timely manner.

Choice Program reimbursement requirements. According to VA and TPA officials, three Choice Program requirements, some of which were more stringent than similar requirements in other federal health care programs, led to claim denials, which, in turn, contributed to the length of time TPAs have taken to pay community providers when the providers did not meet these requirements:

1. **Medical documentation requirement.** Prior to a March 2016 contract modification, VA required providers to submit relevant medical documentation with their claims as a condition of payment from the TPAs.²² According to TriWest officials, those Choice Program claims that did not include medical documentation were classified by TriWest as non-clean claims and placed in pending status until the documentation was received. When community providers did not provide the supporting medical documentation after a certain period of time, TriWest typically denied their claims. According to Health Net officials, Choice Program claims that did not include medical documentation were denied by Health Net.
2. **Timely filing requirement.** VA requires providers to file Choice Program claims within 180 business days from the end of an episode of care.²³ TPAs deny claims that are not filed within the required time frame.
3. **Authorization requirement.** VA requires authorizations for community providers to serve veterans under the Choice Program and receive reimbursement for their services; however, if community providers deliver care after an authorization period or include services that are not authorized, the TPAs typically deny their claims.²⁴

²²Medicare and TRICARE, the Department of Defense's health care program, generally do not require providers to submit medical documentation as a condition of claim payment. See [GAO-16-353](#).

²³Health Net's agreement with its community providers requires the submission of Choice Program claims within 120 business days of the date of service.

²⁴VA officials stated that authorization-related claim denials can occur for many reasons, including the provider delivering care that was not listed on the authorization and the authorization being expired, which can occur if a veteran cancelled the original appointment and rescheduled the appointment outside of the authorization's validity period. In contrast to the Choice Program, Medicare typically does not require authorizations for beneficiaries to obtain care and TRICARE only requires authorizations for certain types of care.

According to TPA data, denials related to authorizations are among the most common reasons the TPAs deny community provider claims.

Inadequate provider education on filing Choice Program claims.

According to VA and TPA officials as well as providers we interviewed, issues related to inadequate provider education may have contributed to the length of time it has taken the TPAs to pay community providers under the Choice Program. These issues have included providers submitting claims with errors, submitting claims to the wrong payer, or otherwise failing to meet Choice Program requirements. For example, some VA community care programs require the claims to be sent to one of VA's claims processing locations, while the Choice Program requires claims to be sent to TriWest or Health Net. Claims sent to the wrong entity are rejected or denied and have to be resubmitted to the correct payer. Ten of the 15 providers we interviewed stated that they lacked education and/or training on the claims filing process when they first began participating in the Choice Program, including knowing where to file claims and the documentation needed to file claims that would be processed successfully. Four of these 10 providers stated that they learned how to submit claims through trial and error.

VA's Monitoring of Claim Payment Timeliness Has Been Limited under the Choice Program, but VA Plans to Strengthen Monitoring under the Veterans Community Care Program

At the infancy of the Choice Program, November 2014 through March 2016, VA was unable to monitor the timeliness of its TPAs' payments to community providers because it did not require the TPAs to provide data on the length of time taken to pay these claims. Effective in March 2016, VA modified its TPA contracts and subsequently began monitoring TPA payment timeliness, requiring TPAs to report information on claims processing and payment timeliness as well as information on claim rejections and denials. However, because VA had not established a payment timeliness requirement, VA officials said that VA had limited ability to penalize TPAs or compel them to take corrective actions to address untimely claim payments to community providers. Instead, the March 2016 contract modification established a non-enforceable goal for the TPAs to process and pay clean claims within 30 days of receipt. As of July 2018, according to VA officials, VA did not have a contractual requirement it could use to help ensure that community providers received timely payments in the Choice Program.

Officials from VA's Office of Community Care told us that VA's experience with payment timeliness in the Choice Program informed VA's RFP for new contracts for the Veterans Community Care Program, which includes provisions that strengthen VA's ability to monitor its future TPAs. For example, in addition to requiring future TPAs to submit weekly reports on claim payment timeliness as well as claim rejections and denials, VA's RFP includes claim payment timeliness standards that are similar to those in the Department of Defense's TRICARE program.²⁵ Specifically, according to the RFP, TPAs in the Veterans Community Care Program will be required to

- process and pay, if approved, 98 percent of clean claims within 30 days of receipt,
- return claims, other than clean claims, to the provider with a clear explanation of deficiencies within 30 days of original receipt, and
- process resubmitted claims within 30 days of resubmission receipt.²⁶

The RFP also identifies monitoring techniques that VA may employ to assess compliance with these requirements, including periodic inspections and audits. VA officials told us that VA will develop a plan for monitoring the TPAs' performance on these requirements once the contracts are awarded.

VA Has Addressed Some but Not All of the Key Factors Affecting the Timeliness of Claim Payments to Community Providers under the Choice Program

We found that VA has made system and process changes that improved its ability to pay TPA invoices in a timely manner. However, while VA has

²⁵TRICARE is the Department of Defense's healthcare program.

²⁶Some of the claim payment timeliness standards in VA's RFP differ from the requirements set forth in the VA MISSION Act of 2018. For example, the act requires VA (or its TPAs) to pay providers within 30 days for claims submitted electronically and within 45 days for claims submitted on paper, whereas the RFP does not differentiate between claims filed electronically or on paper. VA officials told us that they have not determined how to reconcile the differences in the payment timeliness standards.

modified two Choice Program requirements that contributed to provider claim payment delays, it has not fully addressed delays associated with authorizations for care. Furthermore, while VA and its TPAs have taken steps to educate community providers in order to help prevent claims processing issues, 9 of the 15 providers we interviewed reported poor customer service when attempting to resolve these issues.

VA Has Changed Its System and Processes for Paying TPA Invoices in order to Improve Its Ability to Pay TPAs in a Timely Manner

VA has taken steps to reduce untimely payments to its TPAs, which contributed to delayed TPA payments to providers, by implementing a new system and updating its processes for paying TPA invoices so that it can pay these invoices more quickly. Specifically, VA has made the following changes:

- In March 2016, VA negotiated a contract modification with both TPAs that facilitated the processing of certain TPA invoices outside of the fee basis claims system from March 2016 through July 2016.²⁷ According to VA officials, due to the increasing volume of invoices that the TPAs were expecting to submit to VA during this time period, without this process change, VA would have experienced a high volume of TPA invoices entering its fee basis claims system, which could have exacerbated payment timeliness issues.
- In February through April 2017, VA transitioned all TPA invoice payments from its fee basis claims system to an expedited payment process under a new system called Plexis Claims Manager.²⁸ VA officials told us that instead of re-adjudicating community provider claims as part of its review of TPA invoices, Plexis Claims Manager performed up front checks in order to pay invoices more quickly, and any differences in billed and paid amounts were addressed after payments were issued to the TPAs.

²⁷Effective in March 2016, VA decoupled, or removed, the requirement that medical documentation be submitted to the TPA as a condition of claims payment (this contract modification is discussed later in this report). VA allowed the invoices from these “decoupled” claims to be processed outside of the fee basis claims system, while non-decoupled claims continued to be processed through the fee basis claims system. In addition, VA executed contract modifications with Health Net in October 2016 and TriWest in November 2016 that issued lump-sum payments to the TPAs to address backlogged Choice Program claims. The VA OIG examined the accuracy of VA’s lump-sum payments in a report issued in September 2018. See Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Bulk Payments Made under Patient-Centered Community Care/Veterans Choice Program Contracts*, Report No. 17-02713-231 (Washington, D.C.: Sept. 6, 2018).

²⁸This transition occurred for TriWest invoices in February 2017 and for Health Net invoices in April 2017.

- In January 2018, VA transitioned to a newer version of the Plexis Claims Manager that enabled VA to once again re-adjudicate community provider claims as part of processing TPA invoices, but in a timelier manner compared with the fee basis claims system. According to VA officials, this is due to the automation of claims processing under Plexis Claims Manager, which significantly reduced the need for manual claims processing by VA staff that occurred under the fee basis claims system. Based on VA data, as of July 2018, VA is paying 92 percent of TriWest's submitted invoices within 7 days, with payments being made in an average of 4 days, and 90 percent of Health Net's invoices within 7 days, with payments being made in an average of 4 days under the newer version of Plexis Claims Manager.²⁹

In addition to steps taken to address untimely payments to the TPAs under the current Choice Program contracts, VA has taken steps to help assure payment timeliness in the forthcoming Veterans Community Care Program. Specifically, the RFP includes a requirement for VA to reimburse TPAs within 14 days of receiving an invoice. VA officials stated that to achieve this metric, they are implementing a new payment system that will replace Plexis Claims Manager and will no longer re-adjudicate TPA invoices prior to payment.

VA Has Modified Two Choice Program Requirements That Contributed to Provider Payment Delays, but Has Not Fully Addressed Delays Associated with Authorizations for Care

VA has issued a contract modification and waivers for two Choice Program contract requirements that contributed to provider payment delays—(1) the medical documentation requirement and (2) the timely filing requirement. However, while VA issued a contract modification to amend the requirements for obtaining authorizations for Choice Program care, provider payment delays associated with requesting these authorizations may persist, because VA is not ensuring that VA medical centers review and approve these requests within required time frames.

²⁹According to VA officials, payments to TriWest are faster as the invoices TriWest submits typically contain fewer errors than Health Net's invoices. We did not examine the validity or accuracy of VA's statistics.

Elimination of medical documentation requirement. Effective beginning March 2016, VA issued a contract modification that eliminated the requirement that community providers must submit medical documentation as a condition of receiving payment for their claims. Data from one TPA showed a reduction in non-clean claims following the implementation of this contract modification.³⁰ For example, starting in April 2016, after this modification was executed, almost 100 percent of claims submitted to TriWest were classified as clean claims, as opposed to 49 percent of claims submitted in March 2016. However, when the modification first went into effect in March 2016, TriWest and Health Net officials stated that they processed a large amount of claims from community providers that had previously been pended or denied because they lacked medical documentation and, in turn, submitted a large number of invoices to VA for reimbursement. As previously discussed, to help address the increased number of TPA invoices, VA issued lump-sum payments to the TPAs during this time period.

Modification of timely filing requirement. In February and May 2018, VA issued waivers that gave TPAs the authority to allow providers to resubmit rejected or denied claims more than 180 days after the end of the episode of care if the original claims were submitted timely—that is, within 180 days of the end of the episode of care. VA officials stated that the waivers were intended to reduce the number of rejected and denied claims by giving community providers the ability to resubmit previously rejected or denied claims for which the date of service occurred more than 180 days ago. VA's waivers were implemented as follows:

- In February 2018, VA issued a waiver that allowed community providers to resubmit certain claims rejected or denied for specific reasons when the provider or TPA could verify that the provider made an effort to submit the claim prior to the claims submission deadline.³¹
- In May 2018, VA issued a second waiver that removed the 180 day timeliness requirement for all Choice Program claims. The waiver also provided instructions to the TPAs on informing providers that they may resubmit claims rejected or denied for specific reasons and how

³⁰Data from Health Net did not show a reduction in non-clean claims, as Health Net officials told us that claims that were missing medical documentation prior to the implementation of this contract modification were denied.

³¹Some specific reasons for resubmission listed in the waiver include, but are not limited to, paper claims rejected by the TPA due to scanning issues or coding errors.

the TPAs are to process the resubmitted claims.³²

In regards to the first waiver, TPA officials stated that the processing of those resubmitted claims adversely affected the timeliness of the TPAs' payments to community providers because the waiver resulted in a large influx of older claims. As the second waiver was in the process of being implemented by the two TPAs at the time we conducted our work, we were unable to determine if the second waiver affected the TPAs' provider payment timeliness.

Changes to authorization of care requirement. VA issued a contract modification in January 2017 to expand the time period for which authorizations for community providers to provide care to veterans under the Choice Program are valid.³³ In addition, in May 2017, VA expanded the scope of the services covered by authorizations, allowing them to encompass an overall course of treatment, rather than a specific service or set of services.³⁴ According to VA officials, the changes VA made related to the authorization of care requirement were also intended to reduce the need for secondary authorization requests (SAR). Community providers request SARs when veterans need health care services that exceed the period or scope of the original authorizations. Community providers are required to submit SARs to their TPA, which, in turn, submits the SARs to the authorizing VA medical facility for review and approval. Both Health Net and TriWest officials told us that since VA changed the time frame and scope of authorizations, the number of SARs has decreased.

Despite efforts to decrease the number of SARs, payment delays or claim denials are likely to continue if SARs are needed. We found that VA is not ensuring that VA medical facilities are reviewing and approving SARs within required time frames. VA policy states that VA medical facilities are

³²Some specific reasons for resubmission listed in the waiver include, but are not limited to, paper claims rejected by the TPA due to scanning issues or claims incorrectly submitted by the provider to the incorrect payer (for example, Choice Program claims sent to VA directly instead of the TPA).

³³Specifically, the modification extended the validity period of each authorization to 7 days prior to the authorization start date and 60 days after the authorization end date.

³⁴For example, a veteran who requires joint replacement surgery can be expected to receive physical therapy as part of that treatment. With bundled services outlined in the authorization, physical therapy would be covered without the need for an additional authorization.

to review and make SAR approval decisions within 5 business days of receipt.³⁵ However, officials from one of the TPAs and 7 of the 15 providers we interviewed stated that VA medical facilities are not reviewing and approving SARs in a timely manner. According to TriWest officials, as of May 2018, VA medical facilities in their regions were taking an average of 11 days to review and make approval decisions on SARs, with four facilities taking over 30 days for this process.

According to an official from VA's Office of Community Care, VA does not currently collect reliable national data to track the extent of nonadherence to the VA policy to review and make SAR approval decisions within 5 business days. The official told us that instead, VA relies on employees assigned to each Veterans Integrated Service Network to monitor data on VA medical facilities' timeliness in making these SAR approval decisions.³⁶ If a VA medical facility is found not to be in adherence with the SAR policy, the official told us that staff assigned to the Veterans Integrated Service Network attempt to identify the reasons for nonadherence, and perform certain corrective actions, including providing education to the facility.³⁷ Despite these actions, the official told us that there are still VA medical facilities not in adherence with VA's SAR approval policy.

According to a VA official, VA is in the process of piloting software for managing authorizations that will allow VA to better track SAR approval time frames across VA medical facilities in the future. However, even after this planned software is implemented, if VA does not use the data to monitor and assess SAR approval decision time frames VA will be unable to ensure that all VA medical facilities are adhering to the policy. Standards for internal control in the Federal Government state that management should establish and operate monitoring activities to

³⁵See VA Secondary Authorization Request Escalation Guidelines Standard Operating Procedure (Sept. 27, 2016).

³⁶The official told us that data on SAR approval time frames are limited as the system that collects this information was not originally intended to be used to report that type of data. VA's health care system is divided into 18 health care networks, referred to as Veterans Integrated Service Networks, which are responsible for managing and overseeing VA medical facilities within a defined geographic area.

³⁷According to the official, reasons for nonadherence could include a lack of staff and facilities not using time-saving tools VA has made available to them. We have previously identified inadequate staffing at VA medical facilities as a factor that impacts access to care through the Choice Program. See [GAO-18-281](#).

evaluate whether a specific function or process is operating effectively and take corrective actions as necessary. Furthermore, monitoring such data will allow VA to identify and take actions as needed to address any identified challenges VA medical facilities are encountering in meeting the required approval decision time frames. Without monitoring data to ensure that all VA medical facilities are adhering to the SAR approval time frames as outlined in VA policy, community providers may delay care until the SARs are approved or provide care without SAR approval. This in turn increases the likelihood that the community providers' claims will be denied. Further, continued nonadherence to VA's SAR policy raises concerns about VA's ability to ensure timely approval of SARs when VA medical facilities assume more responsibilities for ensuring veterans' access to care under the forthcoming Veterans Community Care Program.

TPAs Have Taken Steps to Improve Provider Education to Help Providers Resolve Claims Processing Issues, but Many Providers Still Report Poor Customer Service

We found that VA and its TPAs have taken steps to educate community providers in order to help prevent claims processing issues that have contributed to the length of time TPAs have taken to pay these providers. Despite these efforts, 9 of the 15 providers we interviewed reported poor customer service when attempting to resolve claims payment issues.

While VA's contracts with the TPAs do not include requirements for educating and training providers on the Choice Program, both TPAs have taken steps to educate community providers on how to successfully submit claims under the Choice Program. Specifically, TriWest and Health Net officials told us that they have taken various steps to educate community providers on submitting claims correctly, including sending monthly newsletters, emails, and faxes to communicate changes to the Choice Program; updating their websites with claims processing information; and holding meetings with some providers monthly or quarterly to resolve claims processing issues. Officials from both TPAs also told us that they provided one-on-one training to some providers on the claims submission process to help reduce errors when submitting claims. In addition, VA's RFP for the Veterans Community Care Program contracts includes requirements to provide an annual training program curriculum and an initial on-boarding and ongoing outreach and education program for community providers, which includes training on the claims submission and payment processes and TPA points of contact.

VA and the TPAs have also made efforts to help providers resolve claims processing issues and outstanding payments. For example,

- VA launched its “top 20 provider initiative” in January 2018 to work directly with community providers with high dollar amounts of unpaid claims and resolve ongoing claims payment issues. This initiative included creating rapid response teams to work with community providers to settle unpaid claim balances within 90 days and working with both TPAs to increase the number of clean claims paid in less than 30 days. In addition, VA has developed webinars on VA’s community care programs and—in conjunction with trade organizations and health care systems—has delivered provider education on filing claims properly.
- TriWest officials stated that it has educated the customer service staff at its claims processing sub-contractor, who field community provider calls regarding claims processing issues, to help ensure that the staff are familiar with Choice Program changes and can effectively assist community providers and resolve claims processing issues. Internal TriWest data show that providers’ average wait time to speak to a customer service representative about claims processing issues decreased from as high as 18 minutes in 2016 to as low as 2.5 minutes in 2018.
- Health Net officials were unable to provide data, but stated that since the fourth quarter of 2017, Health Net has decreased the time it takes for a community provider to speak with a customer service representative by adding additional staff and extending the hours in which providers can call with questions. In addition, Health Net officials stated that they have required customer service staff to undergo additional training related to resolving claims processing issues.

Despite these efforts, 7 of the 10 providers that participate in the Health Net network and 2 of the 7 providers that participate in the TriWest network we interviewed between April and June 2018 told us that when they contact the TPAs’ customer service staff to address claim processing questions, such as how to resolve claim rejections or denials, they experience lengthy hold times, sometimes exceeding one hour. In addition, 7 of the 15 providers we spoke with told us they typically reach employees who are unable to answer their questions. According to these providers, this experience frustrated them, as they often did not understand why a claim had been denied or rejected, and they required assistance correcting the claim so it could be resubmitted. One

community provider stated that their common practice to resolve questions or concerns was to call customer service enough times until they received the same answer twice from a TPA representative. In addition, 5 of the 10 Health Net providers we interviewed stated that they have significant outstanding claim balances owed to them. One of these providers—who reported over \$3 million in outstanding claims—stressed the importance of being able to effectively resolve claims issues with TPA customer service staff, as the administrative burden of following up on outstanding claim balances takes time away from caring for patients.

The issues concerning customer service wait times and TPA staff inability to resolve some claims processing issues reported by community providers appear to be inconsistent with VA contractual requirements. VA's current Choice Program contracts require the TPAs to establish a customer call center to respond to calls from veterans and non-VA providers. The contract requires specified levels of service for telephone inquiries at the call center. For example, VA requires TPA representatives to answer customer service calls within an average speed of 30 seconds or less and requires 85 percent of all inquiries to be fully and completely answered during the initial telephone call. However, VA officials explained that VA does not enforce the contractual requirement for responding to calls from community providers. Furthermore, according to these officials, VA allows the TPAs to prioritize calls from veterans. Officials from VA's Office of General Counsel, Procurement Law Group, confirmed that this requirement does apply to the TPAs' handling of calls from community providers. Because VA does not enforce the customer service requirement for providers, VA has not collected data on or monitored the TPAs' compliance with these requirements for providers' calls.

As previously stated, standards for internal control in the Federal Government state that management should establish and operate monitoring activities to evaluate whether a specific function or process is operating effectively and take corrective actions as necessary. Without collecting data and monitoring customer service requirements for provider calls, VA does not have information on the extent to which community providers face challenges when contacting the TPAs about claims payment issues that could contribute to the amount of time it takes to successfully file claims and receive reimbursement for services under the Choice Program. This, in turn, poses a risk to the Choice Program to the extent that community providers who face these challenges decide not to serve veterans under the Choice Program.

Looking forward, VA has included customer service requirements in its RFP for the Veterans Community Care Program contracts, and VA officials have told us that these requirements are applicable to provider calls. For example, the RFP includes a requirement for its future TPAs to establish and maintain call centers to address inquiries from community providers and has established customer service performance metrics to monitor call center performance.³⁸ Monitoring data on provider calls under the contracts will be important as Veterans Community Care Program TPAs will continue to be responsible for building provider networks, processing claims, and resolving claims processing issues.

Conclusions

The Choice Program relies on community providers to deliver care to eligible veterans when VA is unable to provide timely and accessible care at its own facilities. Although VA has taken steps to improve the timeliness of TPA claim payments to providers, VA is not collecting data or monitoring compliance with two Choice Program requirements, and this could adversely affect the timeliness with which community providers are paid under the Choice Program. First, VA does not have complete data allowing it to effectively monitor adherence with its policy for VA medical facilities to review SARs within 5 days of receipt, which impacts its ability to meet the requirement. To the extent that VA medical facilities delay these reviews and approvals, community providers may have to delay care or deliver care that is not authorized, which in turn increases the likelihood that the providers' claims will be denied and the providers will not be paid. Second, VA requires the TPAs to establish a customer call center to respond to calls from veterans and non-VA providers. However, VA does not enforce the contractual requirement for responding to calls from community providers and allows the TPAs to prioritize calls from veterans. Consequently, VA is not collecting data, monitoring, or enforcing compliance with its contractual requirements for the TPAs to provide timely customer service to providers. As a result, VA does not have information on the extent to which community providers face challenges when contacting the TPAs about claims payment issues, which could contribute to the amount of time it takes to receive reimbursement for services.

³⁸The RFP also includes a requirement for future TPAs to conduct community provider satisfaction surveys.

To the extent that these issues make community providers less willing to continue participating in the Choice Program and the forthcoming Veterans Community Care Program, they pose a risk to VA's ability to successfully implement these programs and ensure veterans' timely access to care.

Recommendations for Executive Action

We are making the following two recommendations to VA:

Once VA's new software for managing authorizations has been fully implemented, the Undersecretary for Health should monitor data on SAR approval decision time frames to ensure VA medical facilities are in adherence with VA policy, assess the reasons for nonadherence with the policy, and take corrective actions as necessary. (Recommendation 1)

The Undersecretary for Health should collect data and monitor compliance with the Choice Program contractual requirements pertaining to customer service for community providers, and take corrective actions as necessary. (Recommendation 2)

Agency Comments

We provided a draft of this report to VA for review and comment. In its written comments, reproduced in appendix I, VA concurred with our two recommendations and said it is taking steps to address them. For example, VA plans to implement software in spring 2019 that will automate the SAR process and allow for streamlined reporting and monitoring of SAR timeliness to ensure ongoing compliance. Additionally, VA has included provider customer service performance requirements and metrics in its Veterans Community Care Program RFP, and will require future contractors to provide a monthly report to VA on their call center operations and will implement quarterly provider satisfaction surveys.

We are sending copies of this report to the Secretary of Veterans Affairs, the Under Secretary for Health, appropriate congressional committees, and other interested parties. This report is also available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Sharon Silas". The signature is fluid and cursive, with the first name "Sharon" and the last name "Silas" clearly distinguishable.

Sharon M. Silas
Acting Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

September 13, 2018

Ms. Sharon Silas
Acting Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***"VETERANS CHOICE PROGRAM: Further Improvements Needed to Help Ensure Timely Payments to Community Providers"*** (GAO-18-671).

The enclosure sets forth the actions to be taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert L. Wilkie".

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VETERANS CHOICE PROGRAM: Further Improvements Needed to Help
Ensure Timely Payments to Community Providers”***
(GAO-18-671)

Recommendation 1: Once VA's new software for managing authorizations has been fully implemented, the Undersecretary for Health should monitor data on SAR approval decision timeframes to ensure VA medical facilities are in adherence with VA policy, assess the reasons for nonadherence with the policy, and take corrective actions as necessary.

VA Comment: Concur. The Department of Veterans Affairs (VA) Office of Community Care (OCC) has been monitoring secondary authorization requests (SAR) timeliness via weekly manual data extractions since March 2016. The current timeframe for SAR adjudication is 5 days. In September 2017, OCC began monitoring SAR timeliness via the OCC Top 8 Metrics report, a report that highlights key performance metrics important to Veterans Integrated Service Network (VISN)/VA medical center (VAMC) community care activities. OCC has trended data from the Top 8 metrics report since September 2017 and has used this information to identify and offer proactive assistance to low performing sites. Weekly calls between OCC Field Support staff, VISN/VAMC Business Implementation Managers, and station leadership have been held to support the lowest performing VISNs. The calls have been used to identify and assess barriers/challenges, agree upon improvement actions, and to provide additional training and tips on process/tool usage to resolve underperformance. As of July 2018, the total number of SARs pending 5 days or greater has been reduced by 56 percent to 22,789 down from 51,985 when monitoring via the Top 8 Metrics report began.

Health Share Referral Manager (HSRM) Version 5, will automate SAR reporting and tracking to allow for streamlined reporting and monitoring of their timeliness. HSRM is a web-based software platform that streamlines the community care referral and authorization process and improves information-sharing between VA and community providers. Critically, HSRM addresses issues with our current referral and authorization business processes that require extensive manual procedures and re-entry of data across disparate systems.

HSRM Version 5 will be released in May 2019, and OCC will utilize its capability to continue leading monitoring efforts to ensure compliance. HSRM is currently being tested at three sites, and implementation across all of the Veterans Health Administration is planned for the Spring 2019. This automation will equip OCC and VISN/VAMC leadership with real-time access to SAR timeliness data to ensure ongoing monitoring and compliance. OCC will continue to work with VISN/VAMC Business Implementation Managers and station leadership to identify barriers and actions for improvement as outliers are noted in the new automated reports. The status is in process with a target completion date of June 2019.

Enclosure

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(GAO-18-671)

Recommendation 2: The Under Secretary for Health should collect data and monitor compliance with the Choice Program contractual requirements pertaining to customer service for community providers, and take corrective actions as necessary.

VA Comment: Concur. VA does not currently have the ability to monitor and assess the performance of customer service operations included in the current Veterans Choice Program (VCP) contracts. The VCP Performance Work Statement (PWS) Section 3(c) includes only a contractual requirement for the Third-Party Administrator (TPA) to establish a call center to provide customer service for community providers and provides guidance for its operations. However, there are no Quality Assurance Surveillance Plans, related to performance monitoring of these operations, nor any mechanisms for the VA to collect data and monitor compliance with the limited VCP contractual requirements.

Moving forward, VA elected to implement call center handling best practices and has included additional requirements for Customer Service in the Community Care Network (CCN) Request for Proposals (RFP). Section 6.2 of the RFP includes requirements for toll-free telephone lines, access to a Real Time Chat function, and automated phone call back to respond to online and telephonic inquiries, and seeks to ensure coverage across a variety of inquiry categories including: status of referrals, prior authorization status, claims status and issues, and complaints.

Section 6.8 of the CCN RFP further details the Call Center Operations and Customer Service Technology Performance Requirements and Metrics. The contractor’s customer service capabilities must meet the performance standards as defined below.

Provider Inquiry Call Center Handling Standards

<u>Metric</u>	<u>Performance Rate</u>
Blockage Rate	less than 5 percent
Call Abandonment Rates	5 percent or less
Average Speed of Answer	30 Seconds or less
First Call Resolution	85 percent or higher
Response Accuracy	90 percent or higher
Real-Time Chat Satisfaction	90 percent or higher

The contractor must provide a monthly report on their call center operations summarizing call center inquiries, performance metrics, open issues, and trends. In addition, Section 6.7 of the CCN RFP provides that the TPA will be required to submit a

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quarterly provider satisfaction survey report of all community providers who submitted claims that quarter. The contractor must report to VA the results of such surveys 60 days following conclusion of the survey quarter. The data provided in the quarterly reports and in the quarterly face to face Performance Management Reviews shall be used to review performance, identify emerging issues and address current issues, and maintain an effective customer service relationship between the contractor and VA. The status is in process with a target completion date of December 2019.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Sharon M. Silas, (202) 512-7114 or silass@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Michael Zose (Analyst-in-Charge), and Kate Tussey made major contributions to this report. Also contributing were Krister Friday, Jacquelyn Hamilton, and Vikki Porter.

Appendix III: Accessible Data

Data Tables

Accessible Data for Figure 3: Median Number of Days to Pay Clean Claims through VA's Third Party Administrators (TPA), November 2014 through June 2018

	Health Net	TriWest
Nov-14	n/a	n/a
Dec-14	n/a	26
Jan-15	21	26
Feb-15	49	26
Mar-15	37	26
Apr-15	36	21
May-15	29	12
Jun-15	20	10
Jul-15	16	8
Aug-15	18	8
Sep-15	28	7
Oct-15	36	10
Nov-15	42	20
Dec-15	33	11
Jan-16	54	26
Feb-16	55	27
Mar-16	30	41
Apr-16	14	41
May-16	15	42
Jun-16	21	51
Jul-16	19	51
Aug-16	23	51
Sep-16	19	58
Oct-16	14	68
Nov-16	10	55
Dec-16	11	49
Jan-17	11	39
Feb-17	12	36

Appendix III: Accessible Data

	Health Net	TriWest
Mar-17	8	35
Apr-17	11	29
May-17	13	29
Jun-17	17	29
Jul-17	18	29
Aug-17	11	29
Sep-17	27	29
Oct-17	9	29
Nov-17	16	28
Dec-17	15	28
Jan-18	28	28
Feb-18	29	26
Mar-18	41	27
Apr-18	44	26
May-18	44	28
Jun-18	29	26

Accessible Data for Figure 4: Median Number of Days to Pay Non-Clean Claims through VA's Third Party Administrators (TPA), November 2014 through June 2018

	Health Net	TriWest
Nov-14	14	n/a
Dec-14	25	38
Jan-15	23	33
Feb-15	17	34
Mar-15	41	34
Apr-15	31	34
May-15	55	33
Jun-15	14	34
Jul-15	42	34
Aug-15	35	45
Sep-15	17	48
Oct-15	9	43
Nov-15	15	42
Dec-15	26	71
Jan-16	35	73

Appendix III: Accessible Data

	Health Net	TriWest
Feb-16	42	59
Mar-16	43	43
Apr-16	28	42
May-16	31	51
Jun-16	33	51
Jul-16	33	53
Aug-16	29	53
Sep-16	27	68
Oct-16	26	69
Nov-16	27	63
Dec-16	24	49
Jan-17	27	39
Feb-17	28	36
Mar-17	28	35
Apr-17	29	35
May-17	30	35
Jun-17	28	34
Jul-17	22	32
Aug-17	25	39
Sep-17	29	43
Oct-17	27	33
Nov-17	29	44
Dec-17	30	36
Jan-18	29	33
Feb-18	31	44
Mar-18	34	33
Apr-18	51	36
May-18	43	37
Jun-18	32	40

Agency Comment Letter

Accessible Text for Appendix I Comments from the Department of Veterans Affairs

Page 1

September 13, 2018

Ms. Sharon Silas Acting Director Health

Care

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

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VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert L. Wilkie

Enclosure

Page 2

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"VETERANS CHOICE PROGRAM: Further Improvements Needed to Help Ensure Timely Payments to Community Providers"

(GAO-18-671)

Recommendation 1: Once VA's new software for managing authorizations has been fully implemented, the Undersecretary for Health should monitor data on SAR approval decision timeframes to ensure VA medical facilities are in adherence with VA policy, assess the reasons for nonadherence with the policy, and take corrective actions as necessary.

VA Comment: Concur. The Department of Veterans Affairs (VA) Office of Community Care (OCC) has been monitoring secondary authorization requests (SAR) timeliness via weekly manual data extractions since March 2016. The current timeframe for SAR adjudication is 5 days. In September 2017, OCC began monitoring SAR timeliness via the OCC Top 8 Metrics report, a report that highlights key performance metrics important to Veterans Integrated Service Network (VISN) NA medical center (VAMC) community care activities. OCC has trended data from the Top 8 metrics report since September 2017 and has used this information to identify and offer proactive assistance to low performing sites. Weekly calls between OCC Field Support staff, VISNNAMC Business Implementation Managers, and station leadership have been held to support the lowest performing VISNs. The calls have been used to identify and assess barriers/challenges, agree upon improvement actions, and to provide additional training and tips on process/tool usage to resolve underperformance. As of July 2018, the total number of SARs pending 5 days or greater has been reduced by 56 percent to 22,789 down from 51,985 when monitoring via the Top 8 Metrics report began.

Health Share Referral Manager (HSRM) Version 5, will automate SAR reporting and tracking to allow for streamlined reporting and monitoring of their timeliness. HSRM is a web-based software platform that streamlines the community care referral and authorization process and improves information-sharing between VA and community providers. Critically, HSRM addresses issues with our current referral and authorization business processes that require extensive manual procedures and re-entry of data across disparate systems.

HSRM Version 5 will be released in May 2019, and OCC will utilize its capability to continue leading monitoring efforts to ensure compliance. HSRM is currently being tested at three sites, and implementation across all of the Veterans Health Administration is planned for the Spring 2019.

This automation will equip OCC and VISNNAMC leadership with real-time access to SAR timeliness data to ensure ongoing monitoring and compliance. OCC will continue to work with VISNNAMC Business Implementation Managers and station leadership to identify barriers and actions for improvement as outliers are noted in the new automated reports. The status is in process with a target completion date of June 2019.

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Recommendation 2: The Under Secretary for Health should collect data and monitor compliance with the Choice Program contractual requirements pertaining to customer service for community providers, and take corrective actions as necessary.

VA Comment: Concur. VA does not currently have the ability to monitor and assess the performance of customer service operations included in the current Veterans Choice Program (VCP) contracts. The VCP Performance Work Statement (PWS) Section 3(c) includes only a contractual requirement for the Third-Party Administrator (TPA) to establish a call center to provide customer service for community providers and provides guidance for its operations. However, there are no Quality Assurance Surveillance Plans, related to performance monitoring of these operations, nor any mechanisms for the VA to collect data and monitor compliance with the limited VCP contractual requirements.

Moving forward, VA elected to implement call center handling best practices and has included additional requirements for Customer Service in the Community Care Network (CCN) Request for Proposals (RFP). Section 6.2 of the RFP includes requirements for toll-free telephone lines, access to a Real Time Chat function, and automated phone call back to respond to online and telephonic inquiries, and seeks to ensure coverage across a variety of inquiry categories including: status of referrals, prior authorization status, claims status and issues, and complaints.

Section 6.8 of the CCN RFP further details the Call Center Operations and Customer Service Technology Performance Requirements and Metrics. The contractor's customer service capabilities must meet the performance standards as defined below.

Metric Blockage Rate

Provider Inquiry Call Center Handling Standards

Performance Rate less than 5 percent

Call Abandonment Rates Average Speed of Answer First Call Resolution
Response Accuracy

Real-Time Chat Satisfaction

5 percent or less 30 Seconds or less

85 percent or higher 90 percent or higher 90 percent or higher

The contractor must provide a monthly report on their call center operations summarizing call center inquiries, performance metrics, open issues, and trends. In addition, Section 6.7 of the CCN RFP provides that the TPA will be required to submit a

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quarterly provider satisfaction survey report of all community providers who submitted claims that quarter. The contractor must report to VA the results of such surveys 60 days following conclusion of the survey quarter. The data provided in the quarterly reports and in the quarterly face to face Performance Management Reviews shall be used to review performance, identify emerging issues and address current issues, and maintain an effective customer service relationship between the contractor and VA. The status is in process with a target completion date of December 2019.

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