Date: March 31, 2015

To: Carrie Hessler-Radelet, Director
Daljit Bains, Chief Compliance Officer

From: Kathy A. Buller, Inspector General

Subject: Management Advisory Report: Peace Corps' Volunteer Healthcare Administration Contract (IG-15-03-SR)

The purpose of this report is to bring to your attention significant concerns the Office of Inspector General (OIG) has with the Peace Corps' contract for administering Volunteer healthcare. We have determined the present contract's solicitation and award process was flawed, and the second contract was not fully compliant with the Federal Acquisition Regulation (FAR). We also questioned the legitimacy of the contract's "network fee" because the Peace Corps likely lacks legal authority to enter into "shared savings" contracts. Further, the contractor did not comply with the terms of the network fee, which, in our opinion may have resulted in higher costs to the Peace Corps. In addition, we noted that a very large claim related to the hospitalization of a former Volunteer was not processed in accordance with federal law, and we found instances where the contractor did not maintain important documentation supporting costs billed to the Peace Corps. Finally, we noted that the agency's contract monitoring process was inadequate. We will issue a full audit report on this subject discussing our findings and conclusions in greater detail.

This report makes six recommendations to improve the agency's actions regarding the Peace Corps' contract for administrating the Volunteer healthcare benefits program. We are requesting your response by **May 15, 2015**. Please provide us with an electronic copy of your signed cover memo and your response. Your response should provide your concurrence or non-concurrence with each recommendation. In addition, please use TeamCentral to document corrective action and upload documentation supporting any actions planned or implemented to address the recommendations.

I. BACKGROUND

While the Peace Corps is self-insured regarding Volunteer covered healthcare benefits, it engages a contractor ("the Contractor") to administer its program for medical services performed outside the Peace Corps' internal medical units. At approximately $35 million over a five-year period, the current contract (PC-12-3-002) is the largest active Peace Corps award.[1] The Volunteers' healthcare coverage typically includes a Volunteer's authorized services prior to leaving the U.S. for assignment; urgent care when med-evac'ed to the U.S. or a third country, or

[1] $35 million is the projected value of the current contract. As of December 2014, the amount of obligated funds for all contracts listed in Table 1 below total over $63 million.

when returned to the U.S. for necessary medical treatment; and health care for a limited time after separating from the Peace Corps and returning home.

A. The Contract. Under the terms of the contract the Contractor is responsible for adjudicating and paying all medical claims the Peace Corps receives from healthcare providers. The Peace Corps then reimburses the Contractor for each payment made. The current contract provides for payment to the Contractor of an annual fixed-fee for administering claims, ranging from $842,588 for the base year of the contract to $965,118 in the final option year. The Peace Corps also pays a network fee which varies in amount but is 30 percent of the cost savings achieved by the contractor for each claim. The Contractor is now performing services in the third of four option years provided under its third contract with the Peace Corps. The current contract expires at the end of the fourth option year, if exercised, on December 31, 2016.

B. The Peace Corps' History with the Contractor. The initial contract with the Contractor (PC-05-3-009) was awarded in August 2005, and was set to expire on September 30, 2010. The contract stipulated it was not to exceed 60 months. However, prior to the contract expiring, the Peace Corps modified the contract twice to extend it for a period of six months beyond the 60-month limit. Prior to the end of the extension period, the Peace Corps awarded the Contractor a noncompetitive contract (PC-11-3-003) for a three-month period as an interim measure to continue services. That contract was then extended for an additional six months. The third and current contract (PC-12-3-002) was awarded on December 30, 2011. The table below summarizes the three contract periods and related extensions.

Table 1. Contracts and Extension Periods

Contract Numbers/Extensions	Time Period
PC-05-3-009	October 1, 2005 – September 30, 2010
Contract Extensions	October 1, 2010 – March 31, 2011
PC-11-3-003	April 1, 2011 – June 30, 2011
Contract Extensions	July 1, 2011 – December 31, 2011
PC-12-3-002	January 1, 2012 – December 31, 2016*

*Through option year four if all options are exercised by the Peace Corps

II. ISSUES

A. Flawed Solicitation and Award Process. The contract extensions and the award of an un-competed and short term second contract resulted from inadequate and untimely acquisition planning. Although it was known in August 2005 that the first contract would expire on September 30, 2010, a replacement contract was not awarded until 15 months after the initial contract expired. During the 15-month period between the expiration of the initial contract and the awarding of the present one, the Peace Corps engaged in questionable contracting practices and at times operated outside the parameters of federal guidance and good business practices. The Peace Corps appeared to struggle with performing its planning for a successor contract and, although not documented in associated files, we concluded that it lacked sufficient resources to timely prepare for the contract solicitation and award. We were informed by a Peace Corps management official that the Office of Health Services (OHS) recognized the requirement for a specialized resource from outside the agency to assist in developing an improved statement of

work describing the services needed. However, this resourcing was denied. Due to the complexity of medical claims cost reimbursement and health care related fee structures we believe the agency should have sought expert advice on how to develop an effective statement of work that would foster increased competition among contractors and the best value for the services sought by the government. Instead, the agency went forward with the statement of work for the 2012 contract that contained key terms and conditions identical to the 2005 contract. [2]

Contract extensions of competitively awarded contracts should be sufficiently justified. We do not agree with Peace Corps management that there was only one responsible source as indicated in its FAR authority for justifying other than full and open competition. This contracting action was taken because of a lack of adequate and timely acquisition planning, which is not considered appropriate and sufficient justification for contracts that are awarded non-competitively. As a result, the contract awarded in April 2011 and its extensions were not FAR compliant.

B. Contract Type Inaccurately Represented. We have determined that the contracts are inaccurately represented as "…firm fixed-price hybrid contract[s] with a combination of firm fixed-price and fixed-rate contract[s]," and should be identified instead as cost-reimbursement plus fixed-fee contracts with an incentive-fee for cost savings. Properly classifying the contracts is key because it determines which FAR provisions govern and which controls must be in place to protect the government's interest.

A review of the current contract shows only 13 percent of the estimated total cost for option year three (CY 2015) represents the fixed-fee for program administration, while the remaining 87 percent of the contract value varies depending on the total value of the claims paid and the total savings the Contractor achieves when adjudicating claims.[3]

Furthermore, the variable portion of the contract does not meet the FAR's definition of a "firm-fixed-price contract":

> A firm-fixed-price contract provides for a price that is not subject to any adjustment on the basis of the contractor's cost experience in performing the contract. This contract type places upon the contractor maximum risk and full responsibility for all costs and resulting profit or loss. It provides maximum incentive for the contractor to control costs and perform effectively and imposes a minimum administrative burden upon the contracting parties.[4]

The contracts were amended multiple times to adjust the funding available for the Contractor to pay claims, and the contracts placed only a limited risk or responsibility on the Contractor for profits or losses. On the contrary, the contracts provide for payment of allowable incurred costs (medical claims), and establish a ceiling that the Contractor could not exceed without the Peace

[2] During the audit OHS advised us that they plan to bring on board an insurance specialist to assist in planning for a new contract to administer the Volunteer health care program.

[3] This portion of the contracts are comprised of two fees: (1) funds which the Contractor draws from to pay medical claims, and which are regularly replenished to ensure the Contractor does not incur costs; and (2) network fees which are 30 percent of the savings achieved in adjudicating claims, amounts which vary depending on the value and amount of the claims adjudicated.

[4] 48 C.F.R. 16.202-1.

Corps' approval. In short, these terms fall squarely within the FAR's definition of cost-reimbursement contracts.[5]

C. Contractor Lacked Consent to Subcontract Key Services. Our review also revealed the Contractor engaged a subcontractor ("the Subcontractor") to assist in the adjudication process through re-pricing of the vast majority of Peace Corps' claims.[6] As discussed above, because the contracts in question were cost-reimbursable the contracting officer was obligated to include a clause in the contract mandated by FAR Part 44 requiring the Contractor obtain consent to subcontract.[7] We found no documented evidence that sub-contracting was authorized by the Peace Corps.[8] Even though the provision was not included in any of the contracts, because the FAR clause is mandatory and expresses such a significant strand of public procurement policy, the clause should be incorporated into the contracts by operation of law. Based on applicable FAR provisions, the Contractor should have been required by the contracting officer to submit its subcontractor for consent by the Peace Corps.[9] Government approval of subcontractors protects the agency by allowing it to vet the parties which will be performing key aspects of the work, including, in this case, handling sensitive medical information.

D. Peace Corps Lacked Authority to Agree to the Network Fee as Structured. The structure of the contracts' network fee, whereby the Peace Corps pays the Contractor a variable fee based on the savings the Contractor achieves when adjudicating medical claims, can only be defined as a shared savings agreement. Shared savings (a.k.a. Shared-in-Savings) contracting is a technique in which a contractor, rather than a client, normally funds the up-front cost of a project, and, in return, receives a percentage of the savings that the contractor generates.[10] In the absence of expressed congressional authority, these contracts are unlawful because they allow agencies to spend unappropriated tax dollars. Here, the Contractor funded the up-front cost of adjudicating claims, and in return, received a percentage of the savings it generated in the form of "network fees."[11] Since the network fees derive from a shared savings agreement, and we are unable to identify congressional authority for the Peace Corps to enter into such agreements, we question the Peace Corps authority to enter into such arrangements and the legitimacy of those fees.

E. Contractor Did Not Comply with the Terms of the Network Fee. Even if the Peace Corps was authorized to agree to the network fee as structured, the Contractor did not comply with its

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[5] 48 C.F.R. 16.301-1.

[6] Under its contract with the Subcontractor, the Contractor agreed to pay a commission of 27 percent for all savings the Subcontractor achieved during the adjudication process. The additional three percent is retained by the Contractor.

[7] Additionally, we assess that the savings fee in the contract could also be determined to be an unpriced contracting action, and/or that because the subcontract was of a type, complexity, and value justifying surveillance to protect the government's interest, the mandatory subcontracting clause should have been incorporated into the contract.

[8] The subcontractor has been used since the beginning of the 2005 contract to adjudicate the vast majority of Peace Corps medical claims and, as a result, manages significant amounts of sensitive Volunteer personal medical data.

[9] 48 C.F.R. 52.244-2(e)(1) requires the Contractor provide the contracting officer several pieces of information regarding its subcontract, but many of those are not found in any of the contracts or proposals incorporated by reference into the contracts. Merely notifying the Peace Corps of the existence of a subcontractor is not enough to satisfy the requirement.

[10] Commercial Use of Share-in-Savings Contracting, January 2003, available at http://www.gao.gov/assets/240/237120.pdf.

[11] http://www.chqpr.org/downloads/SharedSavings.pdf.

terms. The contracts defined the network fee as a percentage of the difference between the Medical Data Research (MDR) fee schedule and the re-priced amount.[12]

However, our review revealed the Contractor never used the MDR, or any other benchmark, to calculate its savings fee and found no documented evidence that the Peace Corps waived the MDR requirement after signing the contracts. Instead, the Contractor calculated its savings fee as a percentage of the difference between the original medical bill and the re-priced amount. The egregiousness of this practice is difficult to overstate. Without using a benchmark – for example, the average or median costs of medical procedures – the government could not be assured that actual cost savings are being achieved. Under this arrangement providers could charge the highest fee possible only to settle with the Contractor for an amount that could still be high above the market average. The Contractor could receive a significant "savings" fee for achieving no real savings at all, at least when comparing the re-priced amount with the average cost of the medical services or with data (over a number of years) of what the government has paid for such services. Without an adequate benchmark the agency has no assurance the incentive fee is achieving any real value and the arrangement exposes taxpayer funds to the possibility of fraud.

The Peace Corps Office of Acquisitions and Contracts Management agreed with our conclusion that the Contractor's non-use of the MDR was a contract compliance issue. As a result, in August 2014, the contracting officer modified the contract to replace the MDR with another usual and customary benchmark. The Contractor agreed to this change and signed the bi-lateral contract modification. Although the modification may solve future non-compliance issues, it does not address the impact of the Contractor's practices since 2005. Also, it is unknown at this time how the modification will impact the Peace Corps' overall costs under the contract.

F. Large Peace Corps Volunteer Claim Improperly Processed. We reviewed a hospital claim billed to Medicare that the Subcontractor improperly processed on behalf of the Contractor. We concluded that the hospital should not have billed Medicare and the Subcontractor should not have accepted it as the payer. Further, the Subcontractor billed the Peace Corps through the Contractor for a network fee calculated as a percentage of the difference between the original hospital bill and the final bill after the Medicare payment. Network fees are typically derived from adjusting medical provider charges using agreed upon network rates or directly negotiating with the provider when a provider does not accept any of the networks used. In this case, the charges were initially covered by Medicare, a federal program. As a result, there were no savings that could be attributed to services performed by the Subcontractor. Furthermore, the charges billed to the government (Medicare and the Peace Corps), included 99.99 percent of the original hospital-billed amount plus a network fee of just over $179,000, exceeding the hospital's original bill by 30 percent. This resulted in total charges to the U.S. government of nearly $774,000 (see Table 2 below). Such billing practices are prohibited by law.

[12] The MDR provided a comprehensive listing of usual and customary medical fees for medical services by geographic area. Its purpose was to compare medical provider billed charges for authorized Volunteer health care services performed to achieve cost reductions through re-pricing.

Table 2. Claim Billing and Payment History

Billed by Hospital & the Contractor	Amount Billed*	Payments Made by U.S. Government
Hospitalization Charges Originally Billed to Medicare by Hospital	$593,409	$593,409
Hospitalization Charges Billed to Volunteer's Estate by Hospital	3,360	-
Hospitalization Charges Billed to Peace Corps by the Contractor	1,132	1,132
Network Fee Billed by the Contractor to Peace Corps	179,031	179,031
Total Amount Paid by U.S. Government before OIG inquiries		$773,572

*Amounts rounded to nearest dollar.

We requested further detail about this claim from the Contractor and Subcontractor, ultimately obtaining the related information through an inspector general subpoena.

Subsequent to OIG inquiries on this transaction, we obtained a letter dated April 24, 2014, from the hospital to the Subcontractor indicating that it agreed to accept $65,298 as payment in full for billed charges of $612,791 minus a previous payment of $1,132. Other information contained in the package indicated a re-calculated network fee of $164,248 derived from Subcontractor-reported savings of $547,493. Based on further discussions with the Contractor we learned that the hospital had credited Medicare for the full amount originally billed and the Subcontractor re-negotiated the hospital charges. According to the Subcontractor documentation, the charges were significantly reduced from $612,791 to $65,298, yielding an 89 percent reduction. There was no explanation given for why the hospital was willing to accept only 11 percent of what was originally billed.

G. Some Medical Claims Tested by OIG Lacked the Required Supporting Documentation. Based on our testing of two separate samples of Peace Corps medical claims we found 25 claims having a total value of about $1.2 million that were not supported by a copy of the medical provider invoice. The Contractor explained that their record keeping of such documents had improved in recent years but that older records were sometimes more difficult to locate because they were comingled with other federal clients' records when archived. While the required, supporting invoices were not available, the Contractor did maintain substantial documentation of the claims and the Contractor review process.

However, the provider invoice is considered key in substantiating the claim. Our sample included claims that were processed by the Contractor between 2005 and 2013 (see Table 3 below for a summary of these testing results).

Table 3. OIG Sampling Test Results

OIG Sample	No. of Claims in Sample	No. of Claims Lacking Support	Value of Claims Lacking Support*
I	197	16	$345,942
II	57	9	$844,518
Totals:	254	25	$1,190,460

*Rounded to the nearest dollar.

H. The Peace Corps' Monitoring of Contractor Performance is Inadequate. Contract monitoring was inadequate and was a significant weak link in Peace Corps' control environment associated with these contracts. As a result, the Peace Corps paid for services not authorized by the contract, the Contractor was not following certain contract terms and conditions, and a lack of sufficient oversight of invoices received for payment caused greater risk that they were not accurate or authorized under the contract. An effective contract monitoring program is critical to ensuring that the government is receiving an acceptable level of services, the Contractor is meeting milestones, and invoicing includes an accurate billing of what has been received and authorized by the contract.

The Contractor/Subcontractor claims adjudication process is very complex in regard to how it works and relates to what is billed to the Peace Corps. Costs are highly variable since the medical provider-billed amounts are re-priced through the adjudication process and the Subcontractor's fees are based on the amount saved on each claim adjudicated. Effective monitoring of this contract requires a high level of understanding of the Contractor/Subcontractor processes and systems used. Further, due to the complexities involved effective monitoring requires that Peace Corps management dedicate sufficient resourcing, including assigning personnel having the appropriate knowledge, skill sets, and experience.

We recommend that:

1. The agency makes it one of its highest priorities to provide sufficient resources to fully assess its needs in administering its Volunteer health care benefits program.

2. The agency thoroughly research feasible alternatives to providing its Volunteers with quality health care benefits, including evaluating the administration needs of this program, and determining the best alternative or combination of alternatives based on its requirements.

3. The agency develop a high quality statement of work that clearly sets out all contract requirements using the assistance of appropriate and necessary technical expertise, including bringing in outside health care insurance experts.

4. The agency ensure that its related research, acquisition planning, solicitation process, evaluation of proposals, and contract award is timely to enable it to transition to a new contract by no later than January 1, 2016.

5. The agency should avoid incorporating all or any part of a contractor's proposal by reference into the related contract for all future contract awards.

6. The agency refrain from entering into shared savings arrangements without specific authority. If such authority is provided, that the agency identify appropriate benchmarks, consider best practices, and assign adequate resources to manage such contracts.

cc: Laura Chambers, Acting Deputy Director/Chief of Staff
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