

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Review of
Patient-Centered
Community Care (PC3)
Provider Network
Adequacy*

September 29, 2015
15-00718-507

ACRONYMS

BIM	Business Implementation Manager
CBO	Chief Business Office
FY	Fiscal Year
IRAC	In-Process Review Advisory Committee
NVC	Non-VA Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
QASP	Quality Assurance Surveillance Plan
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Highlights: Review of VHA's PC3 Provider Network Adequacy

Why We Did This Review

We conducted this review to assess the adequacy of Patient-Centered Community Care (PC3) provider networks developed under Veterans Health Administration's (VHA) contracts valued at approximately \$9.4 billion. This is one in a series of reports we will publish on PC3.

What We Found

Inadequate PC3 provider networks contributed significantly to VA medical facilities' limited use of PC3. VHA spent 0.14 percent, or \$3.8 million of its \$2.8 billion FY 2014 non-VA care (NVC) budget on PC3. During the first 6 months of FY 2015, VHA's PC3 purchases increased but still constituted less than 5 percent of its NVC expenditures. VHA staff attributed the limited use of PC3 to inadequate provider networks that lacked sufficient numbers and mixes of health care providers in the geographic locations where veterans needed them. VA medical facility staff considered the PC3 networks inadequate because:

- The PC3 network lacked needed specialty care providers.
- Returned PC3 authorizations had to be re-authorized through NVC and increased veterans' wait times for care.
- NVC provided veterans more timely care than PC3.

For these staff, inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and

delayed the delivery of care. VHA could not ensure the development of adequate PC3 provider networks because it lacked an effective governance structure to oversee the Chief Business Office's (CBO) planning and implementation of PC3; the CBO lacked an effective implementation strategy for the roll-out of PC3; and neither VHA nor the PC3 contractors maintained adequate data to measure and monitor network adequacy.

What We Recommended

We recommended the Under Secretary for Health strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex healthcare initiatives.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided acceptable plans to complete all corrective actions. We will follow up on their implementation.

A handwritten signature in black ink that reads "Gary K. Abe".

GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

- Objective** We conducted this review to assess the adequacy of Patient-Centered Community Care (PC3) provider networks developed under Veterans Health Administration's (VHA) contracts valued at approximately \$9.4 billion.
- Non-VA Care** Title 38 of the United States Code permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA medical facilities. VA facilities should be the first option for providing veterans medical care, with non-VA care (NVC) used when the facility cannot provide services due to geographic inaccessibility or in emergencies when delays may be hazardous to a veteran's life or health.
- Patient-Centered Community Care** VHA's Chief Business Office (CBO) is responsible for the administration and management of the PC3 program. In September 2013, VA awarded Health Net Federal Services, LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) PC3 contracts totaling approximately \$5 billion and \$4.4 billion, respectively. Under these contracts, Health Net and TriWest are to provide veterans access to a network of providers when VHA facilities cannot provide veterans with timely care. VA also intended the PC3 contracts to replace costly individual NVC authorizations through the use of standardized contract rates.
- Other Information**
- Appendix A provides pertinent background information.
 - Appendix B provides details on our scope and methodology.
 - Appendix C provides comments by the Under Secretary for Health.

RESULTS AND RECOMMENDATIONS

Finding **Patient-Centered Community Care Contractors Did Not Establish Adequate Provider Networks**

We determined that the PC3 contractors did not establish adequate provider networks, and this contributed significantly to VHA's low utilization of PC3 during fiscal year (FY) 2014 and the first half of FY 2015. We found that VA medical facilities generally spent significantly less and purchased fewer types of health care services¹ through PC3 than the NVC program. In FY 2014, VHA PC3 expenditures totaled only about \$3.8 million (0.14 percent) of the total approximate \$2.8 billion VHA spent on NVC.² Although VHA PC3 health care service purchases had increased to about \$34.1 million by the end of the second quarter of FY 2015, PC3 purchases still constituted less than 5 percent of VHA's approximate \$730.4 million in NVC expenditures during this period.

Our survey of the 21 Veterans Integrated Service Network (VISN) Business Implementation Managers (BIM) and visits to 8 VA medical facilities found VHA limited its use of the PC3 contracts due to inadequate PC3 provider networks. They found the PC3 provider networks generally lacked a sufficient number and mix of health care providers in the geographic locations where veterans needed them. They identified the following specific problems related to inadequate PC3 provider networks:

- PC3 networks lacked adequate numbers of providers to deliver needed specialty care.
- Returned PC3 authorizations had to be re-authorized through the NVC program, which increased staffs' administrative work and increased the veterans' waiting time for care.
- NVC provided more timely care to veterans on electronic waiting lists than PC3.

Further, we determined that senior leadership in VHA did not provide the PC3 initiative and contracts valued at approximately \$9.4 billion the proper oversight needed to ensure VHA received adequate provider networks. We found:

¹ All PC3 and NVC service and expenditure comparisons in this report have been adjusted to only compare data for health care services provided by both programs. For example, expenditures for services, such as dental and dialysis, which are provided under NVC but not under the PC3 contracts, have been excluded from our comparative analyses.

² Discussions of FY 2014 PC3 expenditures and authorizations in this report pertain to the 2nd through 4th quarters of the fiscal year because program roll-out did not begin until January 2014.

- VHA lacked an effective PC3 governance structure to provide CBO advice and support and monitor CBO's implementation of PC3.
- CBO staff lacked an effective implementation strategy to ensure adequate VA medical facility outreach and coordination during the roll-out of PC3.
- CBO staff did not ensure the implementation of an adequate quality assurance measure to monitor and assess PC3 network adequacy.

These lapses in VHA and CBO oversight during the planning and implementation of the PC3 initiative significantly impaired the development of adequate PC3 provider networks. As a result, VHA has not been able to use PC3 as intended to provide veterans with access to timely quality health care services and to replace costly NVC authorizations.

Criteria

After the award of the PC3 contracts to Health Net and TriWest on September 3, 2013, the contractors had an implementation period from October 2013 through April 2014 to establish provider networks in 6 geographic regions spanning all 21 of VHA's VISNs. The contractors were to establish adequate provider networks with a sufficient number, mix, and geographic distribution of qualified providers to increase veterans' access to:

- Inpatient and outpatient specialty care
- Limited emergency care
- Limited newborn care for enrolled female veterans following delivery
- Mental health care
- Primary care³

What We Did

We analyzed VHA's summary PC3 and NVC expenditure data. We judgmentally selected a sample of eight VA medical facilities, located in four of the six PC3 regions, to assess their use of PC3. An OIG statistician assisted us in applying a risk-based approach to select the eight VA medical facilities based on the facilities' number of PC3 and NVC authorizations and returned PC3 authorizations. We also received survey responses from 17 of VHA's 21 VISNs and interviewed medical facility managers and staff at the 8 VA medical facilities to determine how network adequacy affected VHA's use of PC3.

Lack of Information To Measure Network Adequacy

VHA lacked detailed specifications for what constituted adequate provider networks in the 6 PC3 regions servicing VHAs' 21 VISNs. Consequently, neither VHA nor the PC3 contractors implemented standards or maintained adequate data to measure and monitor the adequacy of the established PC3 provider networks.

³ VA modified the PC3 contracts on August 8, 2014, to add primary care.

We also could not conduct a more thorough analysis of the scope and breadth of the purchased NVC and PC3 services at the national and medical facility level to assess PC3 network adequacy because VHA lacked key data in its Fee Basis Claims System. VA medical facilities generally did not require staff to input National Provider Identifiers⁴ in the Fee Basis Claims System for providers who had rendered health care services. Thus, the Fee Basis Claims System lacked the critical information necessary for us to identify and compare the specific number and types of providers who provided services under the PC3 and NVC programs and to conduct follow-up if the analyses identified potential provider gaps in the PC3 networks.

**Analysis of
VHA
Expenditures**

In FY 2014, VA medical facility expenditures of approximately \$3.8 million for PC3 health care services did not even surpass VA's initial PC3 investment and payment of approximately \$14.7 million in implementation fees to the PC3 contractors.⁵ Further, the \$3.8 million in PC3 expenditures constituted just under 0.14 percent of VHA's approximate \$2.8 billion in NVC health care expenditures.

PC3 expenditures at the 129 VA medical facilities ranged from \$0 to about \$468,000 with 50 VA medical facilities reporting no expenditures for PC3 health care services. Our analysis of FY 2014 authorizations also showed that VA medical facilities authorized fewer categories of care, 75 categories through PC3 compared to 98 categories of care through NVC. Some of the services VA medical facilities authorized through NVC, but not PC3, included neurosurgery, psychology, and vascular surgery.

Analysis of NVC and PC3 expenditure data for the first 2 quarters of FY 2015 (October 2014 through March 2015) disclosed that VA medical facilities increased their use of PC3, but that it was still very low compared with NVC. Our analysis of PC3 and NVC expenditures and authorizations for this period disclosed that:

- PC3 expenditures had increased to about \$34.1 million but still constituted less than 5 percent of NVC.
- VA medical facility PC3 expenditures ranged from \$0 to about \$4.9 million but 26 VA medical facilities still reported no PC3 expenditures.
- VA medical facilities still only authorized 76 categories of care through PC3 compared with 88 categories of care authorized through NVC during the first 2 quarters of FY 2015.

⁴ National Provider Identifiers are unique identification numbers issued to health care providers by the Centers for Medicare and Medicaid Services.

⁵ *Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings* (Report No. 14-02916-336, April 28, 2015)

*VA Medical
Facility PC3
Expenditure
Analysis*

Our review of the FY 2014 PC3 and NVC expenditure data for the eight VA medical facilities we reviewed showed their PC3 usage was consistent with the national VHA trend. At these eight facilities, PC3 expenditures totaled only about \$278,000, or about 0.09 percent of the medical facilities' approximate \$314.6 million in NVC expenditures in FY 2014. Table 1 shows a comparison of the FY 2014 NVC and PC3 expenditures for each VA medical facility (denoted by numbers) and their supporting PC3 contractor.

Table 1. Comparison of FY 2014 NVC and PC3 Expenditures

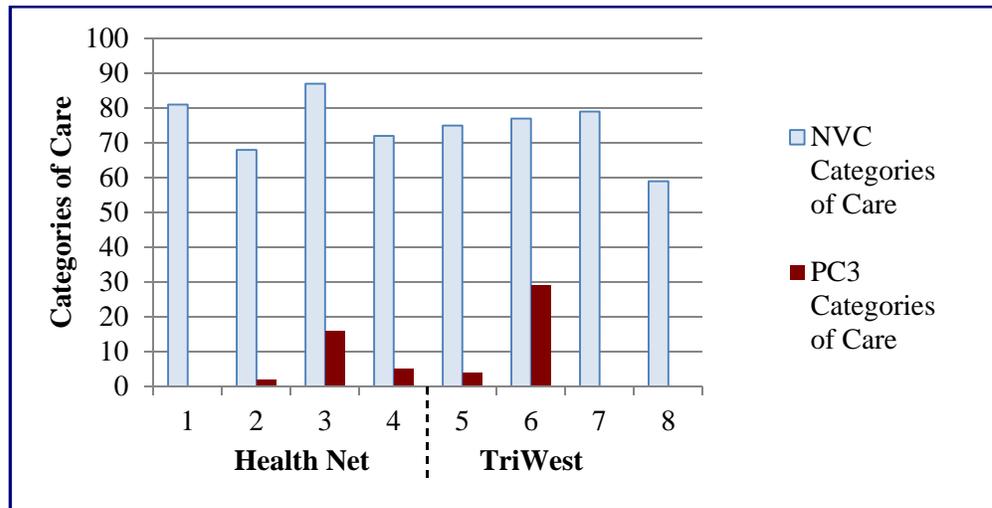
VA Medical Facility and PC3 Contractors	NVC Expenditures (Millions)	PC3 Expenditures	PC3 As Percentage of NVC
1 – Health Net	\$38.5	\$0	0.00%
2 – Health Net	\$15.6	\$5,200	0.03%
3 – Health Net	\$77.8	\$114,000	0.15%
4 – Health Net	\$82.3	\$13,300	0.02%
5 – TriWest	\$59.1	\$3,800	0.01%
6 – TriWest	\$18.3	\$142,000	0.78%
7 – TriWest	\$15.5	\$0	0.00%
8 – TriWest	\$7.6	\$0	0.00%
Total	\$314.6	\$278,000	0.09%

Source: OIG analysis of Fee Basis Claims System data

Note: Because of rounding, columns may not sum.

An analysis of the NVC and PC3 services purchased by the eight VA medical facilities we reviewed in FY 2014 also disclosed that these VA medical facilities purchased a limited number of health care services from the PC3 contractors. These 8 facilities purchased a total of 94 NVC categories of care compared with only 36 categories of care through PC3. Some of the services VA medical facilities purchased through NVC, but not through PC3, included urology, chemotherapy, and cardiology.

Figure 1 provides a comparison of the number of categories of care the eight reviewed VA medical facilities (denoted by numbers and grouped by supporting PC3 contractor) purchased under the NVC and PC3 programs, respectively.

Figure 1. Comparison of FY 2014 PC3 and NVC Categories of Care

Source: *OIG analysis of Fee Basis Claims System Data*

Similar to the national PC3 trend in VHA, these eight VA medical facilities increased their PC3 health care purchases during the first 2 quarters of FY 2015. However, their \$3.8 million in PC3 expenditures still only constituted about 4 percent of their approximate \$100.9 million in NVC expenditures during this period.

VISN Survey and VA Medical Facility Results

Our survey of the 21 VISN BIMs and visits to 8 selected VA medical facilities determined that Health Net's and TriWest's PC3 provider networks could not adequately fulfill VA medical facilities' requests for health care services. During the survey, the VISN BIMs generally reported that VA medical facilities in their areas had encountered a lack of specialty care services and inadequate geographic coverage in their PC3 provider networks. Additionally, the following examples demonstrate the types of network provider problems VA medical facility staffs reported when we asked them about their limited use of the PC3 contracts.

Example 1

One VA medical facility attempted to use Health Net for most of its NVC health care services. However, Health Net returned many of the initial authorizations so the staff decided to send Health Net only less urgent authorizations for services, such as physical therapy and optometry. In October 2014, the staff completely stopped using PC3 because they believed they could obtain more timely health care services and reduce their electronic waiting lists through the use of the NVC program instead.

Example 2

One VA medical facility limited its use of PC3 because TriWest lacked providers that could deliver needed health care services. For example, the NVC staff stated TriWest's provider network included dermatologists, but none were board certified to perform needed Mohs surgeries (skin cancer treatment surgeries). Further, they stated that to use PC3 and to avoid delays in patient care and additional work due to returned authorization, they often

had to check the provider listing on TriWest's PC3 Portal to ensure it had network providers who could perform the needed services before they sent authorizations.

VA paid approximately \$14.7 million in FY 2014 to the PC3 contractors for implementation fees.⁶ However, decisions to limit the use of PC3 as shown in these examples means the sunk costs, the implementation fees VA paid, did not produce adequate provider networks.

Staff at five of the eight VA medical facilities we visited also specifically expressed concerns about the PC3 contractors returning authorizations without veterans receiving the services they needed. For these staff, possible returned authorizations due to inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans' waiting times, staffs' administrative workload, and delayed the delivery of care

During the OIG's *Review of Allegations of Delays in Care Caused by Patient-Centered Community Care (PC3) Issues*⁷, the OIG found that the PC3 contractors were not meeting contract timeliness requirements for returning PC3 authorizations to VHA and that these delays, in some cases, adversely affected patients. The PC3 contracts require the contractor to create appointments within 5 business days of receipt of the authorization. However, the OIG projected that Health Net took an average of 15 days and TriWest took an average of 21 days to return authorizations after they could not schedule appointments.

Further, an example from that OIG report demonstrated the adverse effect inadequate PC3 provider networks had on patient care: On July 11, 2014, VA medical facility staff learned that TriWest returned 172 of 192 gastroenterology authorizations submitted from May through July 2014 due to a lack of TriWest network providers. Since these consults were already significantly delayed, VA medical facility staff immediately began reviewing the 172 returned authorizations and determined that 57 patients were symptomatic for potentially significant conditions, such as cancer and needed priority scheduling. VA medical facility staff spent the following week reviewing, prioritizing, and scheduling appointments for these 57 priority veterans. Staff continued to schedule the remaining 115 veterans with non-VA care providers in the community once the priority veterans' appointments had been processed.

Due to inadequate PC3 provider networks, VA medical facilities have decided to not use or to limit their use of PC3, and VHA cannot ensure that

⁶ *Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings* (Report No. 14-02916-336, April 28, 2015)

⁷ *Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues* (Report No. 14-04116-408, July 1, 2015).

the \$15.1 million it invested in the implementation of PC3 will be an effective use of funds.

Reasons PC3 Is Not Working as Intended

PC3 provider networks are inadequate and are unable to provide veterans access to timelier care because VHA did not exercise sufficient due professional care and diligence during the implementation of this initiative. VHA did not ensure the:

- Establishment of an effective governance structure to oversee a national health care initiative of this complexity and cost
- Development of an adequate implementation strategy to roll out the program
- Development and inclusion of an effective performance measure in the PC3 contracts' Quality Assurance Surveillance Plans (QASP) to assess and monitor PC3 provider network adequacy

Lack of Effective Governance Structure

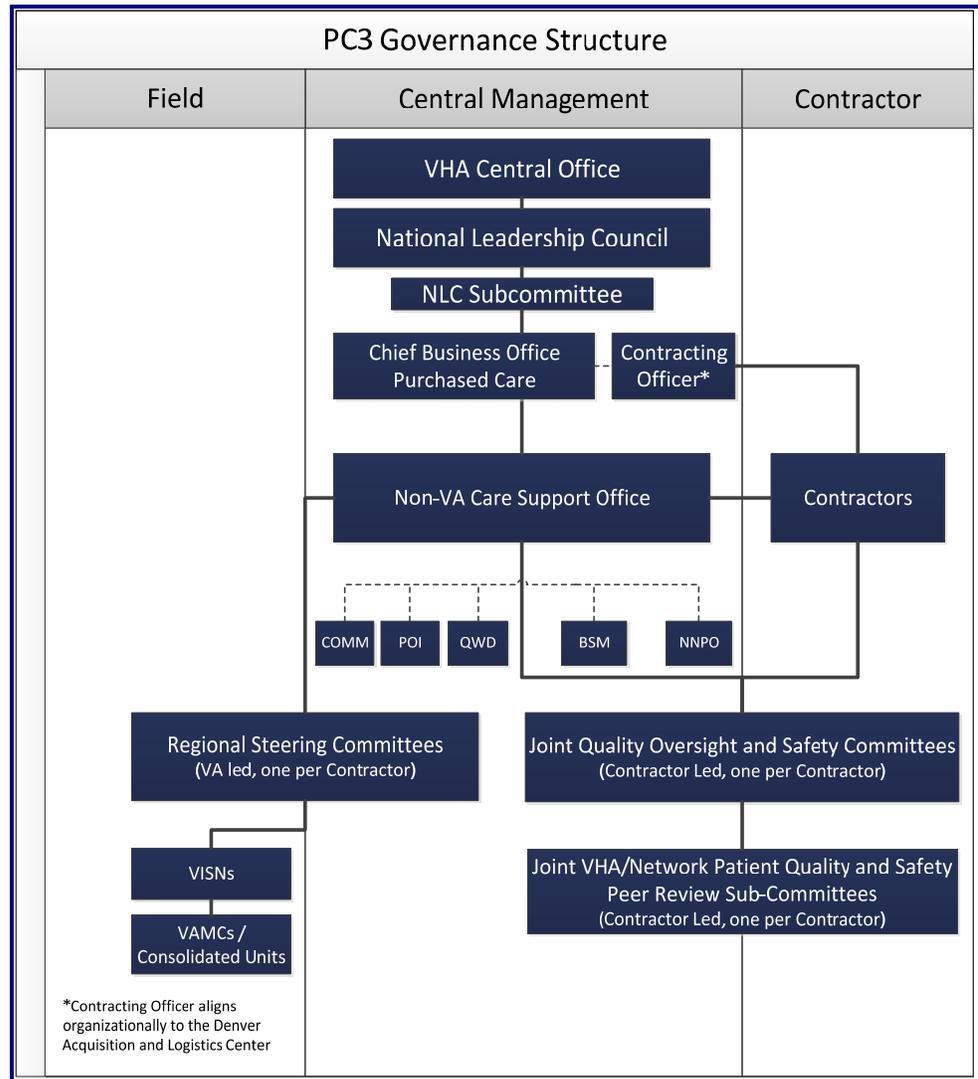
VHA did not ensure the establishment of an effective governance structure to ensure CBO properly implemented and monitored PC3. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states agency management needs to comprehensively identify risks and should consider all significant interactions within the agency and with external parties. Senior management and program management need to compare actual performance with planned or expected results and analyze significant differences.

Through the PC3 initiative, VHA sought strategically to give veterans additional access to health care when they could not receive timely care at VA medical facilities. Considering this initiative entailed the projected expenditure of about \$9.4 billion over the 5-year contract period (base year plus 4 option years), we found VA did not exercise sufficient due diligence and adequately identify and implement controls to mitigate the high degree of risks associated with developing and maintaining health care provider networks in urban, rural, and highly rural areas throughout VHA's 21 VISNs.

We found a document that showed VHA planned to establish a governance structure to monitor the PC3 contracts. However, this was not formalized until February 2014, or about 5 months after the award of the PC3 contracts.

Figure 2 shows the diagram of the proposed PC3 governance structure from a February 2014 draft VHA PC3 governance charter. VHA initially envisioned a PC3 governance structure where the CBO Purchased Care Office would report to the National Leadership Council and draw upon various offices in the CBO NVC Support Office and external committees of VISN, VA medical facility, and PC3 contractor staff to support and advise it.

Figure 2. Diagram of VHA PC3 Governance Structure



Source: Department of Veterans Affairs, Patient-Centered Community Care Governance Charter, February 2014, (Draft)

Despite the placement of the National Leadership Council in this governance structure, the National Leadership Council was only supposed to fulfill a minimal role in PC3 and to be involved only with high-level oversight and the establishment of VHA standards in support of the Under Secretary. Hence in May 2014, the Assistant Deputy Under Secretary for Health for Administrative Operations sought to strengthen the governance structure of PC3 by adding an oversight body to monitor the PC3 program. He issued a memo forming the PC3 In-Process Review Advisory Committee (IRAC) with members including the Deputy Chief Business Officer for Purchased Care and Deputy Assistant Secretary for Office of Acquisitions and Logistics.

IRAC's purpose was to hold quarterly reviews and advise CBO on the integrity, accountability, relevance, effectiveness, sustainability, and coordination of the PC3 program. In addition, IRAC was also supposed to evaluate the patient-centered care aspect of the PC3 program, including improved access to care.

Despite VHA's plans to provide adequate senior leadership oversight after the award of the PC3 contracts, we found no indications that IRAC ever met. IRAC's only meeting scheduled in August 2014 was canceled due to lack of participation by committee members and some committee members we interviewed were unaware they were members of IRAC. According to the Chief Business Officer, the Deputy Under Secretary for Health for Operations and Management subsequently advised CBO to rescind the IRAC to avoid redundancy with the Field Advisory Committee, which was originally established to provide monthly reports to the IRAC regarding assurance and oversight of the execution of the PC3 contracts. With the rescission of the IRAC, it is unclear what senior leadership body within VHA actively reviews and monitors the CBO's management of the PC3 initiative.

*Lack of an
Effective
Implementation
Strategy*

We found that CBO lacked an effective implementation strategy to improve coordination and understanding of PC3 between VA medical facilities and the PC3 contractors. The PC3 contractors stated that CBO staff did not allow them to have detailed discussions with the VA medical facilities in their regions to identify their specific health care needs until February 2014. According to the PC3 contractors, this delay occurred because CBO wanted to manage the introduction of the PC3 program to the VA medical facilities. As a result, the PC3 contractors did not conduct any significant PC3 coordination and outreach efforts with VA medical facilities until February 2014, more than 5 months after the award of the PC3 contracts and only 2 months prior to the date the provider networks were to be completed.

Further, we noted that CBO did not send representatives with the PC3 contractors during VA medical facility site visits. CBO staff acknowledged that they did not travel to VA medical facilities when the PC3 contractors conducted their site visits and that they only participated via teleconference due to travel budget constraints. CBO needed a more effective implementation strategy during the initial PC3 roll-out to:

- Effectively introduce the PC3 program to the VA medical facilities and establish effective communications with the medical facilities and regional PC3 contractors
- Provide the PC3 contractors VA medical facility specific information on the needed health care services and the geographic locations where the services were needed

- Identify and address potential implementation issues early in the process that could affect accessibility and the timely delivery of patient care

A former senior CBO official advised us that CBO did not become aware of the full extent of the significant PC3 implementation issues until July 2014. CBO held a meeting to assess national PC3 usage, reasons for low utilizations, and to develop an action plan. CBO's NVC Support Office indicated in the action plan that it planned to set up joint meetings with VISN Directors, BIMs, PC3 contractor leadership, and contracting officers to address low usage. Further, the CBO sought to:

- Assess PC3 provider network capability to support VISN requirements
- Address training needs
- Conduct site visits to address VA medical facility concerns
- Conduct weekly calls with the BIMs, PC3 contractors, and contracting officers

In August 2014, CBO began providing VA medical facility staff online training and presentations on such topics as PC3 administration, clinical components, and consults and authorizations. This occurred almost 4 months after the PC3 contractors' April 2014 deadline to establish provider networks and about 11 months after the award of the PC3 contracts.

Without a clear PC3 implementation strategy and early and extensive outreach efforts, CBO staff could not facilitate the VA medical facilities' early use of PC3, the PC3 contractors' development of adequate provider networks, or the resolution of problems identified during the first year of the PC3 contracts.

Lack of an Effective Network Adequacy Performance Measure

CBO did not ensure the development and inclusion of an effective performance measure to monitor the adequacy of PC3 provider networks in the PC3 contracts' QASPs. PC3's success depended on Health Net's and TriWest's development of networks with a sufficient number and mix of health care providers in the geographic locations where veterans needed them. Under Federal Acquisition Regulation, QASPs enable the Government to perform contract quality assurance at such times and places as necessary to determine whether procured supplies or services conform to contract requirements. Therefore, QASPs should identify the areas to be monitored, the standards for acceptable performance, and the data to be used to monitor and measure performance in the identified areas.

Despite the importance of PC3 network adequacy in ensuring veterans receive access to needed health care services, the PC3 QASP network access performance measure focused solely on veterans' commute times to providers. Table 2 shows the QASP network access performance standard for the three main types of PC3 contracted care.

Table 2. PC3 Network Access Standard in Commute Minutes

Contracted Care	Urban Area	Rural Area	Highly Rural Area
Standard Level	45	100	180
Higher Level	90	180	*
Primary Care	30	45	60

Source: VA's PC3 Contracts

*Highly Rural standard for higher level of care is "Community Standard," which in practice is the closest provider willing and able to see the veteran.

For this QASP standard, the PC3 contractors self-reported their performance measurement data and simply divided the number of medical appointments that met the commuting standard into the total number of completed appointments. If the contractors reached a threshold of 90 percent or more, VA considered the network access adequate. Based on CBO-approved PC3 contractor performance reports, Health Net's and TriWest's network access performance was about 86 percent and 91 percent, respectively, in FY 2014. Table 3, on the following page, provides a summary of FY 2014 network access performance data by PC3 contractor and region.

Table 3. FY 2014 Network Access Performance Data by PC3 Contractor Region

Health Net Regions	Health Net Network Access Performance	TriWest Regions	TriWest Network Access Performance
Region 1	82%	Region 3	87%
Region 2	86%	Region 5	92%
Region 4	87%	Region 6	96%
Health Net Regions	86%	TriWest Regions	91%

Source: Health Net's and TriWest's Monthly Performance Reports

Note: All Regions had performance reports as of January 2014, except Regions 3 and 6 which did not have reports until April 2014.

Thus, contracting staff deemed Health Net's provider network access just below adequate and TriWest's provider network access adequate during FY 2014. Based on the PC3 contractors' performance reports for October and November 2014, Health Net's performance remained at about 86 percent while TriWest's performance decreased to about 85 percent during the first 2 months of FY 2015.

We did not consider this QASP performance measure an adequate measure of network access since contracting staff lacked the ability to independently verify the reliability and accuracy of the contractors' self-reported PC3 data. More importantly, the network access performance measure did not take into account the adequacy of the PC3 provider networks and cases where VA medical facility staff did not use PC3 because they knew from prior experience that the PC3 networks could not provide veterans needed services.

Further, VHA and the PC3 contractors did not systematically gather adequate data and monitor network adequacy after the award of the PC3 contracts because it was not part of the QASP. In our opinion, VHA needed to monitor and measure network adequacy before it could effectively and accurately assess network access. Thus, the QASP should have:

- Established PC3 provider network adequacy standards based on the number and mix of needed specialty providers and the forecasted need for services in the VA medical facilities' specific geographic locations
- Required the review of the PC3 contractors' provider lists and analysis of completed PC3 authorizations by provider and geographic location to assess the condition of the PC3 provider networks
- Compared the results of PC3 network assessments with the applicable provider network adequacy standards to determine if the networks provided veterans adequate access

Contracting staff indicated the PC3 QASP network access performance measure only addressed commute times because they did not know what the VA medical facilities' needs for health care services were at the time they awarded the contracts. This occurred because CBO, which was responsible for overseeing the development and implementation of the PC3 initiative, did not provide the contracting officer with the key data needed to develop an adequate performance measure for network access. Consequently, the PC3 QASP network access measure did not allow VHA to effectively monitor and measure the PC3 networks' ability to provide veterans needed health care services.

Conclusion

VA medical facilities have significantly limited their use of PC3 due to inadequate provider networks. Thus, VHA has not been able to use PC3, as it intended, to provide veterans with timelier access to care and to reduce NVC costs. VA medical facility staff limited their use of PC3 because they do not consider it a better option to NVC. Attempts to use inadequate PC3 networks have reportedly increased patient waiting times, delays in care, and VA medical facilities' administrative work.

The current situation was precipitated by VHA's lack of an effective governance structure to monitor and implement the PC3 initiative. Without

an effective governance structure in place, VHA could not ensure CBO exercised due professional care and diligence in its management of the PC3 initiative. Consequently, CBO lacked an effective PC3 implementation strategy to foster the outreach and collaboration between the VA medical facilities and PC3 contractors needed to develop adequate provider networks. Further, CBO did not provide contracting staff with critical information that was needed to establish an effective contract performance measure to monitor the adequacy of PC3 provider networks.

Recommendations

1. We recommended the Under Secretary for Health ensure the establishment of an adequate governance structure to oversee and improve Patient-Centered Community Care management and operations.
2. We recommended the Under Secretary for Health ensure adequate implementation and performance monitoring plans are developed for future high-dollar, complex health care initiatives.
3. We recommended the Under Secretary for Health assess where Patient-Centered Community Care provider networks are inadequate and develop action plans to improve provider networks that are unable to provide health care services at the specific geographic locations identified.
4. We recommended the Under Secretary for Health ensure the Patient-Centered Community Care Quality Assurance Surveillance Plan is revised to address the monitoring and measurement of network adequacy.
5. We recommended the Under Secretary for Health require the input of National Provider Identifier information for rendering providers in the Fee Basis Claims System to ensure adequate data are available for program evaluation and planning.

Management Comments

The Under Secretary for Health agreed with our findings and recommendations and plans to address our recommendations by August 2016. CBO Purchased Care will form a workgroup to develop a new PC3 governance structure to oversee and improve PC3 management and operations.

CBO Purchased Care will reference lessons learned from PC3 when future implementation and performance monitoring plans are developed for future complex health care initiatives. CBO Purchased Care will conduct round tables with VISNs, medical facility representatives, and CBO staff and based on the lessons learned, a guide will be created to ensure adequate implementation and performance monitoring plans.

CBO Purchased Care developed an action plan that addresses low PC3 contract utilization rates. A key element includes the current NVC Network Capacity Pilot, which facilitates efforts between the VISN Directors and medical facility leadership to expand the use of the PC3/Choice contract by addressing potential provider network adequacy issues. VISNs and medical facilities were asked to work directly with the contractors to address areas for opportunities.

CBO Purchased Care will incorporate PC3 provider network adequacy oversight into the new PC3 governance structure. Research will be conducted to develop a PC3 provider network adequacy monitoring plan, to implement and incorporate into the Quality Assurance Surveillance Plan.

Finally, CBO Purchased Care recently identified a technical issue that prevents rendering provider NPI numbers from moving from the Electronic Data Interchange clearinghouse into the Fee Basis Claims System. Once assessments are complete to fully understand the problem, system modifications will be made to ensure the rendering NPI information is submitted on PC3 claims.

OIG Response

The Under Secretary for Health provided a responsive action plan and comments to address our recommendations. We will monitor VA's progress and follow up on its implementation until all proposed actions are completed.

Appendix A Background

Program Office

CBO is organizationally aligned under VHA's Deputy Under Secretary for Health for Operations and Management. CBO oversees the development of administrative processes, policy, regulations, and directives for the delivery of VA health care benefits programs to veterans. The CBO Purchased Care Office is responsible for programs, such as NVC (formerly the Fee Basis Program), where veterans and their dependents receive health care services external to VA. The Purchased Care Office established the Program Management Office to oversee the PC3 program. The Program Management Office for the PC3 contracts performs outreach at the VISNs and VA medical facilities to answer questions about PC3 and gain an understanding of the users' needs.

Non-VA Care

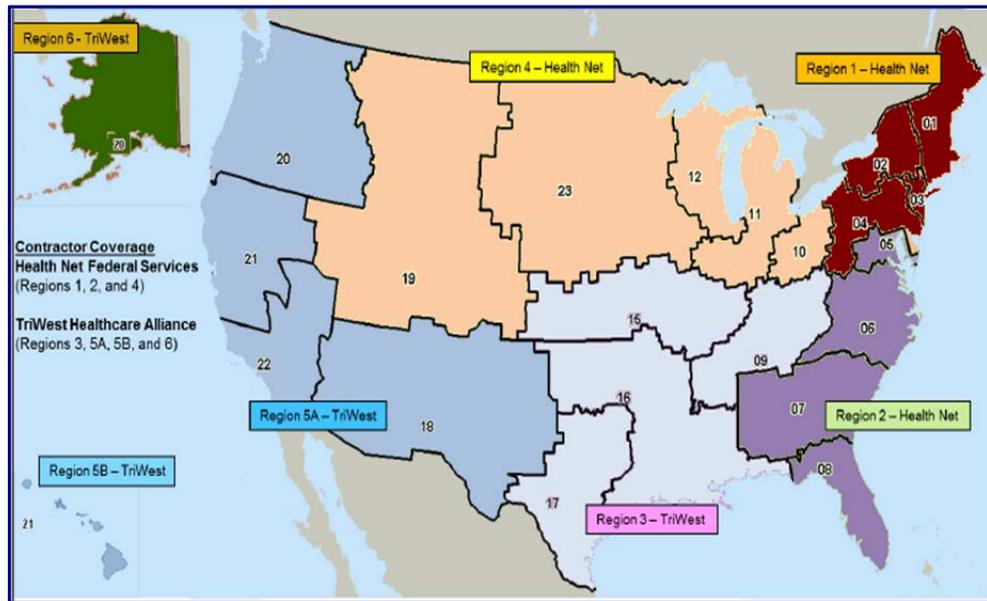
Title 38 of the United States Code permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA medical facilities. VA bases the payment amount on the applicable Medicare or VA Fee Schedule rates. Pre-authorizations for treatment are required for NVC except for emergencies. Additional care needed or recommended beyond the scope of the initial authorization must be approved by the medical facility that authorized the care. VA medical facilities should be the first option for providing veterans medical care, with NVC used when the facility cannot provide services due to geographic inaccessibility or in emergencies when delays may be hazardous to a veteran's life or health.

Patient-Centered Community Care

PC3 is a component of NVC. VA uses PC3 health care contracts to provide eligible veterans access to care when VA cannot readily provide the care either at a VA medical facility or through other Federal agencies or sharing agreements. Care may not always be readily available due to demand exceeding capacity, geographic inaccessibility, and other limiting factors.

PC3 Contractors

In September 2013, VA awarded Health Net and TriWest PC3 contracts totaling about \$5.1 billion and about \$4.4 billion, respectively. The contractors had an implementation period from October 2013 through April 2014 to establish their provider networks in 6 geographic regions spanning all 21 of VA's VISNs. Figure 3 shows the contractors' PC3 regions.

Figure 3. Map of PC3 Regions

Source: VA Web site, www.va.gov

VA evaluated the PC3 contractors' performance based on elements in the QASP, including the timeliness of completing veteran appointments, return of medical documentation, and veteran commute times. The contractors are required to submit monthly performance reports for the elements outlined in the QASP.

Project HERO

Project Health Care Effectiveness Through Resource Optimization (Project HERO) served as the model for PC3. Project HERO provided veterans contracted specialty and dental care in four VISNs when services were not readily available from VA. VA reported that about 87 percent of Project HERO veterans were able to schedule an appointment within 30 days and that about 92 percent of their outpatient medical documentation was returned within 30 days. In addition, VA reported that Project HERO saved a total of about \$25 million from January 1, 2008, through June 30, 2013. VA stated that PC3 contracts would replace costly individual authorizations by standardizing rates through contractual agreements, provide services to veterans when and where they needed them, and ensure VA received medical documentation of the contracted care.

Besides expanding coverage to all 21 VISNs, the main difference between PC3 and Project HERO is that PC3 established limits on acceptable commute times for veterans to obtain services in urban, rural, and highly rural areas. Project HERO did not place limits on the distance veterans traveled to obtain services.

Prior OIG Reports

The OIG previously reported that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates prevented VA

from achieving its FY 2014 \$13 million PC3 cost saving estimate in *Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings* (Report No. 14-02916-336, April 28, 2015). In addition, OIG's *Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues* (Report No. 14-04116-408, July 1, 2015) found PC3 contract care issues caused delays in patient care and pervasive dissatisfaction with the PC3 program.

Appendix B Scope and Methodology

Scope

We conducted our review from November 2014 through August 2015. We surveyed the 21 VISN BIMs and visited 8 selected VA medical facilities to obtain their perspective of PC3. For these eight sites, we obtained the population of disbursed PC3 and NVC payments made for authorizations in FY 2014. We also reviewed FY 2014 and 2 quarters of available FY 2015 PC3 expenditure data. The eight VA medical facilities visited include:

- El Paso, Texas
- Fayetteville, Arkansas
- Gainesville, Florida
- Harlingen, Texas
- Helena, Montana
- Little Rock, Arkansas
- Orlando, Florida
- Salt Lake City, Utah

Methodology

To accomplish our objectives, we interviewed CBO program officials, contracting staff, and PC3 contractors to obtain information regarding contract award, program implementation, and PC3 provider network development. Further, we surveyed the VISN BIMs and interviewed staff at eight selected VA medical facilities visited to obtain user perspectives of the PC3 contracts. Using FY 2014 NVC and PC3 authorization data, we judgmentally selected the eight medical facilities based on a combination of the following criteria:

- Highest count of NVC authorizations
- Highest count of PC3 authorizations
- Lowest count of PC3 authorizations
- Highest count of PC3 returned authorizations

The eight VA medical facilities covered four of six PC3 regions with four medical facilities each supported by Health Net and TriWest. For these reviewed medical facilities, we also compared expenditures and the number of specialties used between NVC and PC3.

Data Reliability

We obtained computer-processed data from VA's Corporate Data Warehouse and Central Fee's Post Payment files to identify PC3 authorizations and expenditures for FY 2014 and the first two quarters of FY 2015. To test the reliability of these data, we compared it with data extracted from VA's National Data Systems, Fee Basis, and Financial Management System by the OIG's Data Analysis Division. Our testing of the data disclosed that they were sufficiently reliable for our review objectives.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix C Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 9, 2015
From: Under Secretary for Health
Subj: OIG Draft Report, Review of Patient-Centered Community Care (PC3)
Provider Network Adequacy (VAIQ 7636313)
To: Assistant Inspector General for Audits and Evaluations (52)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1 through 5.
2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.



David J. Shulkin, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan**

OIG Draft Report, Review of Patient-Centered Community Care (PC3) Provider Network Adequacy

Date of Draft Report: August 13, 2015

Recommendations/ Actions	Status	Completion Date
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Recommendation 1. We recommended the Under Secretary for Health ensure the establishment of an adequate governance structure to oversee and improve Patient-Centered Community Care management and operations.

VHA Comments: Concur

The Veterans Health Administration's (VHA) Chief Business Office Purchased Care (CBOPC) will form a workgroup to develop a new Patient-Centered Community Care (PC3) governance structure. Upon approval by identified VHA stakeholders, the new PC3 governance structure will be put in place to oversee and improve PC3 management and operations moving forward. VHA's oversight consolidation plan may influence any further governance structure for PC3.

To complete this action plan, VHA will submit:

- Documentation (i.e., organization chart, charter) that outlines the new PC3 governance structure for review by OIG.

Status: In process	Target Completion Date: February 2016
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Recommendation 2. We recommended the Under Secretary for Health ensure adequate implementation and performance monitoring plans are developed for future high-dollar, complex health care initiatives.

VHA Comments: Concur

VHA's CBOPC agrees that there are opportunities to improve implementation planning and performance monitoring planning for future complex health care initiatives. While an applicable effort has not yet been identified, CBOPC believes capturing the lessons learned from PC3 will provide a valuable artifact to reference while future implementation and performance monitoring plans are constructed. To ensure a comprehensive review, CBOPC will conduct round tables with Veterans Integrated Service Network (VISN) and Veterans Affairs Medical Center (VAMC) representatives, as well as, CBO staff to obtain valuable insight from all stakeholders on PC3 topics that

include, but are not limited to implementation planning and performance monitoring. CBO will draft and share a white paper documenting what is learned from these round table discussions with project and program managers for reference when implementation planning and performance monitoring plans are being developed for any future health care initiative. Based on the lessons learned outcome, the development of a guide will be created to assist future program managers with qualitative expectations, check-off list, and other value added information to ensure adequate implementation and performance monitoring plans.

To complete this action plan, VHA will submit:

- PC3 Lessons Learned white paper.
- If applicable, standard operating procedures outlining expectations for health care initiative implementation and performance monitoring.

Status:
In process

Target Completion Date:
March 2016

Recommendation 3. We recommended the Under Secretary for Health assess where Patient-Centered Community Care provider networks are inadequate and develop action plans to improve provider networks that are unable to provide health care services at the specific geographic locations identified.

VHA Comments: Concur

VHA's CBOPC developed an action plan that addresses low PC3 contract utilization rates. A key element includes the current Non-VA Care Network Capacity Pilot, which is an effort to work one-on-one with VISN Network Directors, and facilitates in efforts to expand their use of the PC3/Choice contract by addressing potential provider network adequacy issues. These site visits engaged VISN and VAMC leadership to build support for use of the PC3 contracts, discussing areas of greatest discord, and specialties with opportunities for improvement. VISNs and VAMCs were then asked to work directly with the contractors to address areas for opportunities. The contractors also engaged with the VISNs and VAMCs based on their assessment of needs.

To complete this action plan, VHA will submit:

- Approved action plans for improving PC3 utilization by building the PC3 provider networks.

Status:
Completed

Completion Date:
August 2015

Recommendation 4. We recommended the Under Secretary for Health ensure the Patient-Centered Community Care Quality Assurance Surveillance Plan is revised to address the monitoring and measurement of network adequacy.

VHA Comments: Concur

To develop a successful monitoring plan that measures provider network adequacy, VHA's CBOPC needs to first define network adequacy, determine how it will be measured, and identify acceptable variance levels to account for geographical area challenges. CBOPC will incorporate PC3 provider network adequacy oversight into the new PC3 governance structure. CBOPC will research methodologies for monitoring and measuring provider network adequacy and identify industry best practices. Based on this research, CBOPC will develop a PC3 provider network adequacy monitoring plan, and upon approval, implement and incorporate it into the Quality Assurance Surveillance Plan (QASP).

To complete this action plan, VHA will submit:

- Documentation that demonstrates how PC3 provider network adequacy oversight has been incorporated into the governance structure.
- Deployment of an approved PC3 provider network monitoring plan.
- Modified QASP to include network adequacy monitoring.

Status:
In process

Target Completion Date:
August 2016

Recommendation 5. We recommended the Under Secretary for Health require the input of National Provider Identifier information for rendering providers in the Fee Basis Claims System to ensure adequate data is available for program evaluation and planning.

VHA Comments: Concur

VHA's CBOPC agrees that the rendering National Provider Identifier (NPI) number will aid in further evaluating provider network adequacy and PC3 program evaluation and planning. VHA CBOPC recently identified a technical issue that is preventing rendering NPI numbers from moving through the Electronic Data Interchange clearinghouse into the Fee Basis Claims System. Once assessments are complete to fully understand the

problem, system modifications will be made to resolve. VHA CBOPC will also ensure that rendering provider NPI information is submitted on PC3 claims to improve information available for program evaluation and planning.

To complete this action plan, VHA will submit:

- Documentation that demonstrates deployment of applicable system modifications.

Status:
In process

Target Completion Date:
April 2016

Veterans Health Administration

September 2015

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Janet Mah, Director Rhiannon Barron Gregory Gladhill Herlin Guerra-Sagastume Sunny Lei Andrea Lui Andrea Sandoval Nelvy M. Viguera Butler
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