

**STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"CHOICE CONSOLIDATION: IMPROVING VA COMMUNITY CARE
BILLING AND REIMBURSEMENT"
FEBRUARY 11, 2016**

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) work concerning VA's purchase care programs. Our work covers issues discussed in VA's *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care* (consolidation plan), submitted to Congress as required by Public Law 114-41, Surface Transportation and Veteran Health Care Choice Improvement Act. I am accompanied by Mr. Larry Reinkemeyer, Director, OIG's Kansas City Audit Division.

BACKGROUND

VA's purchased care programs include the Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), Fee Basis Care, and other non-VA care programs. VA's purchased care programs are critical to VA in carrying out its mission of providing medical care, including outpatient services, inpatient care, mental health, dental services, and nursing home care to veterans. Our audits and reviews have reported the challenges VA faces in administering these programs, such as authorizing, scheduling, ensuring contractors provide medical information to VA in support of the services provided, ensuring VA inputs the medical information from contractors into the veteran's VA medical record, and timely and accurate payment for care purchased outside the VA health care system. Specifically, we reported in January 2015, and October 2015, that the Phoenix VA Health Care System (PVAHCS) was experiencing problems coordinating administrative actions with contracted providers including timely insertion of contracted providers' medical documentation into VA medical records.¹ We determined that non-VA providers' clinical documents were not available for PVAHCS providers to review timely and that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to non-VA clinical records. We also concluded that PVAHCS Urology Service and Non-VA Care Coordination staff did not provide timely care or ensure timely urological services were provided to patients needing care.

¹ *Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ, January 28, 2015; and Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ, October 15, 2015*

It has been challenging to conduct effective oversight of VA's purchase care programs because VA continues to fast track changes to the program. For example, we had planned to review the timeliness and accuracy of PC3 payments this fiscal year after providing VA sufficient time to process a significant number of PC3 medical claims to make reliable findings and conclusions. However, PC3 was soon followed by the VCP, which has only paid about \$53 million of medical claims as of February 1, 2016. Nevertheless, we plan on reviewing a statistically reliable number of paid Choice medical claims every quarter in order to meet the Veterans Access, Choice, and Accountability Act (VACAA) of 2014 (Public Law 113-146) requirement to submit a report on timeliness and accuracy after 75 percent of the almost \$10 billion dollars appropriated to the VCP is spent or when the program ends in August 2017, whichever occurs first. This approach enables us to view the expenditure activity over time and helps assess whether the program services provided to veterans are improving or worsening. The planned approach also provides more time and opportunity for VA to strengthen its program controls specifically before the majority of funds are spent.

PATIENT-CENTERED COMMUNITY CARE

The PC3 program is a Veterans Health Administration (VHA) nationwide program that provides eligible veterans access through health care contracts to certain medical services. The PC3 program is used after the VA medical facility has exhausted other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. In September 2013, VA awarded Health Net Federal Services, Limited Liability Corporation (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) PC3 contracts totaling approximately \$5 billion and \$4.4 billion, respectively. Then on October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of the VCP. Administration includes responsibilities such as, sending out Choice cards to eligible veterans, providing call center service, scheduling appointments, and providing care through their provider networks. This is an important matter when evaluating VA's plan to align all non-VA care programs under the new VCP. Since Health Net and TriWest have built their Choice provider network upon the backbone of their PC3 network, there are lessons that can be learned from the series of reports we issued in FY 2015 addressing aspects of PC3 implementation efforts. A theme that was clear to us was that VA clinical and support staff were dissatisfied with PC3 in such areas as authorizing care, scheduling appointments, and veterans waiting for care.

In our July 2015, [*Review of Allegations of Delays in Care Caused by Patient-Centered Community Care \(PC3\) Issues*](#), we examined VHA's use of PC3 contracted care to determine if it was causing patient care delays. We found that pervasive dissatisfaction with both PC3 contracts has caused all nine of the VA medical facilities we reviewed to stop using the PC3 program as intended. We projected Health Net and TriWest returned, or should have returned, almost 43,500 of 106,000 authorizations (41 percent)

because of limited network providers and blind scheduling.² We determined that delays in care occurred because of the limited availability of PC3 providers to deliver care. VHA also lacked controls to ensure VA medical facilities submit timely authorizations, and Health Net and TriWest schedule appointments and return authorizations in a timely manner. VHA needed to improve PC3 contractor compliance with timely notification of missed appointments, providing required medical documentation, and monitoring returned and completed authorizations. The then Interim Under Secretary for Health agreed with our recommendations to ensure PC3 contractors submit timely authorizations, evaluate the PC3 contractors' network, revise contract terms to eliminate blind scheduling, and implement controls to make sure PC3 contractors comply with contract requirements.

In our September 2015, [Review of VHA's PC3 Provider Network Adequacy](#), we reported that 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 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 non-VA care 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, such as urologists and cardiologists.
- Returned PC3 authorizations had to be re-authorized through non-VA care and increased veterans' wait times for care.
- Non-VA care 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. Further, VHA had not ensured 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 Health Net and TriWest maintained adequate data to measure and monitor network adequacy. The Under Secretary for Health agreed with our recommendations to strengthen controls over the monitoring of PC3 network adequacy and ensure adequate implementation and monitoring plans are developed for future complex healthcare initiatives.

In another September 2015 report, [Review of Patient-Centered Community Care \(PC3\) Health Record Coordination](#), we found that VA lacked an effective program for monitoring the performance of their two contractors. We estimated that about 32 percent of the PC3 episodes of care had complete clinical documentation provided

² Blind scheduling refers to scheduled appointments for veterans without discussing the tentative appointment with the veteran.

within the time frame required under the PC3 contracts. This was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation. Contracting Officer's Representatives (CORs) did not have an independent source of VA data to verify contractor compliance with the contracts. Instead, CORs monitored contract compliance by reviewing monthly performance reports submitted by the contractors. As a result, VA lacked adequate visibility and assurance that veterans were provided adequate continuity of care, and VA was at an increased risk of improperly awarding incentive fees or not applying penalty fees. We estimated 20 percent of the documentation was incomplete, and an additional 48 percent was not provided to VA within the timeframe required in the contracts. From January 1 through September 30, 2014, we estimated that VA made about \$870,000 of improper payments.

Additionally, we reviewed just over 400 episodes of care and identified 3 critical findings that did not have contract-required elements annotated in the clinical documentation returned by TriWest's providers, such as the name of the VA medical facility staff member contacted and date and time notified. Without this information and the timely receipt of critical findings, VHA lacked assurance that critical findings were being reported in accordance with the contract's performance standards. Further, we examined each critical finding and found that PC3 patients experienced delays in treatment by VA, as well as by TriWest. We made recommendations to the VA Undersecretary for Health including to implement a mechanism to verify PC3 contractors' performance, ensure PC3 contractors properly annotate and report critical findings in a timely manner, and impose financial or other remedies when contractors fail to meet requirements.

The Under Secretary for Health provided a responsive action plan and expected to address our recommendations by August 2016. We are continuing to monitor VA's progress and will do so until all proposed actions are completed.

VETERANS CHOICE PROGRAM

The VACAA created the VCP in November 2014. Following enactment of VACAA, VA turned to Health Net and TriWest, the administrators of the PC3 program, who had provider networks in place nation-wide. The VCP allows staff to identify veterans to include on the Veterans Choice List, a list that includes veterans with appointments beyond 30 days from the clinically indicated or preferred appointment dates and veterans who live more than 40 miles from a VA facility. Under this program, VA facilities began providing non-VA care to eligible veterans enrolled in VA health care as of August 1, 2014, and to recently discharged combat veterans who are within 5 years of their post-combat separation date. From August 2014 through February 1, 2016, VA has spent \$224.4 million on the VCP. VA has reimbursed Health Net and Tri West \$171.4 million of the \$224.4 million (76 percent) for administering the program and \$53.0 million of the \$224.4 million (24 percent) for medical services provided to veterans.

Our OIG Hotline has received numerous complaints about the VCP during the 4th quarter of fiscal year 2015. These complaints fall into the following general categories:

- Appointments and scheduling
- Program eligibility and enrollment
- Veteran and provider payments
- Authorization process.

In our February 2016, [Review of Alleged Untimely Care at the Colorado Springs Community Based Outpatient Clinic, Colorado Springs, Colorado](#), we substantiated the allegation that eligible Colorado Springs veterans did not receive timely care in six reviewed services. These services were Audiology, Mental Health, Neurology, Optometry, Orthopedic, and Primary Care. We reviewed 150 referrals for specialty care consults and 300 primary care appointments. Of the 450 consults and appointments, 288 veterans encountered wait times in excess of 30 days. For all 288 veterans, VA staff either did not add them to the Veterans Choice List or did not add them to the list in a timely manner.

- For 59 of the 288 veterans, scheduling staff used incorrect dates that made it appear the appointment wait time was less than 30 days.
- For 229 of the 288 veterans with appointments over 30 days, Non-VA Care Coordination staff did not add 173 veterans to the Veterans Choice List in a timely manner and they did not add 56 veterans to the list at all.
- In addition, scheduling staff did not take timely action on 94 consults and primary care appointment requests.

As a result, VA staff did not fully use VCP funds to afford Colorado Springs CBOC veterans the opportunity to receive timely care. The Eastern Colorado Health Care System Acting Director agreed with recommendations to ensure scheduling staff use the clinically indicated or preferred appointment dates for primary care appointments, use the earliest appropriate date for scheduling new patient consult appointments, place veterans with appointments over 30 days on the Veterans Choice List within 1 day of scheduling the appointment, and provide sufficient resources to act on consults within 7 days and appointment request for newly enrolled veterans within 1 day. Based on actions already implemented, we closed the recommendation to ensure that scheduling staff use the clinically indicated or preferred appointment dates when scheduling primary care patient appointments.

In our February 2016 report, [Review of Alleged Patient Scheduling Issues at the VA Medical Center in Tampa, Florida](#), we substantiated that when veterans received appointments in the community through the VCP, the facility did not cancel their existing VA appointments. For example,

- We found that for 12 veterans, staff did not cancel the veterans' corresponding VA appointments because Non-VA Care Coordination staff did not receive prompt

notification from the contractor when a veteran scheduled a VCP appointment and no longer needed the VA appointment.

- We also substantiated that the facility did not add all eligible veterans to the Veterans Choice List when their scheduled appointment was greater than 30 days from their preferred date, and that staff inappropriately removed veterans from the Veterans Choice List.

This occurred because Tampa VAMC schedulers thought they were appropriately removing the veteran from the Electronic Wait List, when they were actually removing the veteran from the Veterans Choice List. The Director agreed with our recommendations to ensure the facility receives prompt notification of scheduled VCP appointments, determine if the contractor complies with the notification requirements, ensure appropriate staff receive scheduling audit results and staff verify correction of errors, and ensure staff receive training regarding management of the Veterans Choice List. Based on actions already implemented, we closed 4 of the 5 recommendations, and will follow up to ensure the facility receives prompt notification of scheduled VCP appointments.

In addition to the audit required under VACAA, we have also initiated another national audit. We are reviewing the implementation of VCP to determine if there are barriers preventing veterans' access to the program and whether VA has effectively communicated with veterans and providers about the program.

NON-VA MEDICAL CARE OBLIGATIONS

Sound financial stewardship of funds for purchased care is important to ensure the availability to pay providers. VA uses miscellaneous obligations to estimate the funding requirements needed to ensure that it does not overspend for a variety of goods and services, including non-VA Care. Beginning in FY 2015, the VACAA required the CBO to use special use funds to pay for non-VA Care services. If CBO de-obligates those funds after the fiscal year ends, those resources can no longer be used to create new non-VA Care authorizations for veterans waiting for services. VA is required to ensure that funds are available to cover the non-VA Care obligation and expenditure prior to entering into an agreement to purchase medical services. Once non-VA Care services are approved, the respective budget and/or finance office is responsible for verifying that funds are available and authorized, and the obligation is recorded in the financial system.

In our January 2016 report, [*Audit of Non-VA Medical Care Obligations*](#), we determined that VHA had overestimated, and thus over obligated, \$543 million out of \$1.9 billion (29 percent) of non-VA Care funds obligated as of the end of FY 2013. The \$1.9 billion represented open obligations for which VA had not yet made payments at the end of FY 2013. The \$543 million represented an over obligation of those funds as they were not needed to make such payments. The \$543 million consisted of about \$265 million of single-year funds, and \$278 million of no-year funds. As a result, over obligated single-year funds were at risk of being unused and returned to the U.S. Department of Treasury due to expiration of the appropriation, and although no-year funds do not

expire, they remain unavailable for current needs until deobligated. The overestimates occurred for several reasons, including the lack of adequate tools for medical center staff to reasonably estimate the costs of purchased care and weaknesses in the financial reconciliation processes. VHA also did not ensure that unused funds were deobligated after payments were complete.

If VHA does not improve non-VA Care obligation management, VA medical facilities are likely to continue to over obligate funds, thus reducing the amount of funds facilities have available to spend on non-VA Care. In addition, beginning in FY 2015 the VACAA effectively prohibits VA from using no-year funds for non-VA Care, which puts all over obligated non-VA Care funds at risk of being unavailable for any purpose. VACAA also limited the VA's ability to transfer funds between non-VA Care and other Medical Services obligations, such as medical salaries. These restrictions increase the importance of accurately estimating non-VA Care obligations to maximize the amount funds used to provide care for veterans while minimizing the amount of unused funds that expire and are ultimately returned to the Treasury Department.

We contract with CliftonLarsonAllen LLP (CLA) to audit VA's consolidated financial statements. For the year ending September 30, 2015, they reported processing and reconciliation issues related to purchased care as a material weakness.^[1] CLA increased its focus on purchased care given increased funding and implementation of the VACAA. CLA reported problems with the cost estimation process and additionally noted the lack of reconciliation between the Fee Basis Claims System used to authorize, process, and pay for non-VA Care and VA's Financial Management System where obligations are recorded.

All of these issues—lack of tools to estimate non-VA Care costs, lack of controls to ensure timely deobligations, and weaknesses in reconciling non-VA Care authorizations to obligations in the Financial Management System—makes the accurate and timely management of purchased care funds challenging. To address the challenges in estimating costs, VA has requested legislation that would allow VA to record an obligation at the time of payment rather than when care is authorized. In its consolidation plan, VA said this would likely reduce the potential for large deobligation amounts after the funds have expired. VA cites the Department of Defense's Tricare program as an example of a large program with similar authority.

We recognize that the current process and system infrastructure are complex and do not provide for effective funds management. We caution that such a change alone—i.e., obligating funds at the time of payment—would not necessarily remove all of VA's challenges in this area. VA would still need adequate controls to monitor accounting, reconciliation, and management information processes to ensure they do not spend more than appropriated by Congress.

^[1]*Audit of VA's Financial Statements for Fiscal Years 2015 and 2014*, November 16, 2015.

CONCLUSION

Our audits and reviews have shown that VA faces challenges in administering its purchased care programs. Veterans' access to care, proper expenditure of funds, and timely payment of providers are at risk to the extent that VA lacked adequate processes to manage these funds and oversee program execution. While purchasing health care services from non-VA providers may afford VA flexibility in terms of expanded access to care and services that are not readily available at VA medical facilities, it also poses a significant risk to VA when adequate controls are not in place. With non-VA health care costs of about \$6 billion in FY 2015 and future costs expected to increase, VA needs to improve program controls. Without adequate controls, VA's consolidation plan is at increased risk of not achieving its goal of delivering timely and efficient health care to veterans.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or members of the Committee may have.