

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Department of Veterans Affairs

*Review of  
VA's Patient-Centered  
Community Care (PC3)  
Contracts' Estimated Cost  
Savings*

April 28, 2015  
14-02916-336

# ACRONYMS

CBO	Chief Business Office
DALC	Denver Acquisition and Logistics Center
eCMS	Electronic Contract Management System
FAR	Federal Acquisition Regulation
FY	Fiscal Year
PC3	Patient-Centered Community Care
PMO	Program Management Office
POI	Office of Program Oversight and Integrity (Chief Business Office)
HERO	Health Care Effectiveness through Resource Optimization
OIG	Office of Inspector General
QASP	Quality Assurance and Surveillance Plan
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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# Report Highlights: Review of VA's PC3 Contracts' Estimated Cost Savings

## Why We Did This Audit

In April 2014, the Office of Inspector General (OIG) received a request from the U.S. House of Representatives Committee on Appropriations to review VA's Patient-Centered Community Care (PC3) costs. VA's budget submission stated PC3 contracts would save it \$13 million, respectively, in Fiscal Years (FYs) 2014 and 2015. This report is one in a series of planned reports assessing aspects of VA's implementation of PC3.

## What We Found

We could not attest to the reliability and accuracy of VA information regarding the methodology and calculation of the PC3 cost savings estimate due to a lack of documentation and because officials could not provide reliable information about the cost saving estimate's development. Our analysis determined that inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates impeded VA from achieving its \$13 million PC3 cost saving estimate in FY 2014. VA paid approximately \$18.9 million in FY 2014, to the PC3 contractors: \$15.1 million (80 percent) for implementation and administrative fees and \$3.8 million (20 percent) for health care services.

These same health care services would have cost about \$4.0 million if they had been purchased under the non-VA care program. This occurred because VA did not conduct adequate price analyses to support its cost savings estimate.

Further, VA lacked an implementation plan to ensure the utilization of PC3. Thus, VA could not ensure it achieved the estimated cost savings and recouped the fees paid to the PC3 contractors. VA simply assumed that the PC3 contractors would develop adequate provider networks; medical facilities would achieve the desired utilization rates; and the accrued PC3 cost savings for health care services, would more than offset the contractors' fees. These flawed assumptions contributed to significant PC3 contract performance problems and a 9 percent utilization rate in FY 2014.

## What We Recommended

We recommended the Interim Under Secretary for Health revise VA's PC3 cost analyses and address VA's low PC3 utilization rates. Additionally, we recommended the Executive Director, Office of Acquisition, Logistics, and Construction, ensure all required contract documents are maintained in the PC3 contract files.

## Agency Comments

The Interim Under Secretary for Health and Executive Director, Office of Acquisition, Logistics, and Construction, concurred with our report and provided acceptable plans to complete all corrective actions. We will follow up on their implementation.

Handwritten signature of Linda A. Halliday in blue ink.

LINDA A. HALLIDAY  
Assistant Inspector General  
for Audits and Evaluations

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## RESULTS AND RECOMMENDATIONS

### **Question**      **Did Use of Patient-Centered Community Care Contracts Save VA \$13 Million in FY 2014?**

In April 2014, the U.S. House of Representatives Committee on Appropriations requested the OIG review VA's Patient-Centered Community Care (PC3) contract costs and its \$13 million FY 2014 cost savings estimate. VA reported in its FY 2014 Funding and FY 2015 Advance Appropriations Request (Budget Submission) that PC3 contracts would allow it to standardize its non-VA care processes and rates and to replace costly individual non-VA care authorizations. VA estimated that implementation of PC3 would help it save \$13 million in both FYs 2014 and 2015.

**What We Did**      To address the House Appropriations Committee's request, we evaluated VA's PC3 cost savings estimate methodology and analyzed FY 2014 PC3 contract costs and authorizations to determine if VA achieved a \$13 million cost savings. We performed site visits and interviewed program and contracting staff at Veterans Health Administration (VHA) Chief Business Office Purchased Care Office and Denver Acquisition and Logistics Center (DALC) to obtain information on PC3 program implementation, oversight, and contract costs. We also visited two VA medical facilities to evaluate PC3 processes and obtain their perspectives on the utilization of the contracts. Finally, we analyzed FY 2014 PC3 contract expenditure data from the Chief Business Office's Program Oversight and Informatics (POI) office to determine PC3 costs.

**What We Found**      We determined that VA did not achieve its estimated \$13 million cost savings in FY 2014. VA paid Health Net Federal Services, LLC and TriWest Healthcare Alliance Corporation (PC3 Contractors) a total of about \$18.9 million in FY 2014. It paid about \$15.1 million (80 percent) for implementation and administrative fees and the remaining \$3.8 million (20 percent) for health care services provided to veterans.

Of the \$15.1 million paid to the PC3 contractors in FY 2014, for implementation and administrative fees, approximately \$14.7 million (97 percent) was used to pay implementation fees. VA paid about \$389,300 in administrative fees for just over 6,900 completed PC3 authorizations. These administrative fees were based on the number, type (inpatient or outpatient), and geographic location of the provided services.

VA awarded the PC3 contracts based on the contractors' proposals which stated the contractors had established health care provider networks from previous contracts. For example, Health Net Federal Services, LLC stated that it had previously provided health care services under a Department of

Defense TRICARE program contract. VA included implementation fees in the PC3 contracts to cover the development of PC3 provider networks<sup>1</sup> to meet veterans' health care needs and other key program administration costs such as:

- Provider network development, credentialing, and training
- Authorization creation
- Appointment processing
- Medical documentation collection
- Claims processing and submission
- Systems configuration and reporting
- Quality management

Although these costs could be spread over the expected life of the contract (base year plus four option years), they were all front-loaded into the first year of the PC3 contracts with the fees paid when the PC3 contractors met contract milestones. VA accepted milestones that paid for the PC3 contractors' program implementation costs before the contractors began providing health care services. This was despite the potential risk of VA not electing to exercise the contracts' option years if performance problems arose in the future.

Under the non-VA care program, VA generally pays for health care services rendered at the applicable Medicare or VA Fee Schedule rate. When we applied the appropriate Medicare rate to the health care services purchased under PC3, we determined that these services would have cost about \$4 million if they had been purchased under the non-VA care program using Medicare rates. In a direct comparison of expenditures, VA spent about \$18.9 million to purchase services under the PC3 contracts while we calculated that these same services would have cost about \$4 million through the non-VA care program. Thus, VA paid about \$14.9 million more to purchase health care service under the PC3 contracts than if it had used individual non-VA care authorizations.

A better comparison prorates the PC3 expenditures for the implementation fee over the contract base year plus the four option years. In this scenario, the PC3 contracts' annualized implementation fees totaled approximately \$2.9 million. However, the adjusted FY 2014 PC3 contract costs still totaled about \$7.1 million (\$2.9 million in implementation fees, plus \$389,300 in administrative fees, plus \$3.8 million cost for health care services provided to veterans) compared to about \$4.0 million for the same services under the non-VA care program.

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<sup>1</sup> Appendix A provides a map of the six PC3 networks and the geographic areas covered.

Despite prorating the implementation fees to better match the expenses incurred to the cost savings expected from these contracts, VA still spent about \$3.1 million more for PC3 contract health care services than if it had used individual non-VA care authorizations in FY 2014.

Table 1 compares VA's total PC3 contract and non-VA care costs and shows that the PC3 contracts' implementation and administrative fees made it virtually impossible for VA to achieve the estimated \$13 million cost savings through the purchase of PC3 health care services in FY 2014.

**Table 1. Comparison of FY 2014 PC3 and Non-VA Care Costs**  
(in thousands of dollars)

<b>Payment Category</b>	<b>Health Net (a)</b>	<b>TriWest (b)</b>	<b>PC3 Costs (a+b=c)</b>	<b>Non-VA Care Costs (d)</b>	<b>PC3 Cost Savings (d) - (c)</b>
Health Care Services	\$1,477	\$2,299	\$3,776	\$3,955	\$179
Implementation Fees	\$8,556	\$6,124	\$14,680	\$0	\$(14,680)
Administrative Fees	\$387.8	\$1.5	\$389.3	\$0	\$(389.3)
<b>Total</b>	<b>\$10,420.8</b>	<b>\$8,424.5</b>	<b>\$18,845.3</b>	<b>\$3,955</b>	<b>\$(14,890.3)</b>

Source: *OIG Analysis of Reported PC3 and Non-VA Care Health Care Costs*

\* *Costs were rounded for this comparison.*

*Unsupported Cost Savings Estimate*

VA lacked sufficient price analysis to support its \$13 million cost savings estimate. Since one of the primary objectives of the PC3 contracts was to reduce VA's non-VA care costs, we expected the estimated contract costs and potential to achieve the \$13 million cost savings to be fully explained and documented in the PC3 contract files. Although we found evidence in the contract files that the DALC contracting staff discussed the potential PC3 cost savings during the contract award process, the contracting files lacked supporting documentation for the methodology, assumptions, and data used to calculate the \$13 million cost savings estimate.

The PC3 contract files in VA's Electronic Contract Management System (eCMS) lacked documentation such as adequate acquisition plans showing how VA reasonably expected to achieve the reported \$13 million cost savings. We could initially only locate two unsigned "draft" acquisition plans in eCMS that provided an estimate of the contracts' costs without any supporting rationale or explanation for the estimated cost savings. A signed acquisition plan was uploaded to eCMS in late December 2014, almost

3 years after it was signed. We also searched for other documents to identify the \$13 million cost savings and found that other pertinent contract files, such as the independent government cost estimate, were not in eCMS.

FAR and VA acquisition policies require the contract files to include documentation to support key activities in contract development. While the FAR allows agencies to retain contract files in any storage medium, VA transitioned from a hard copy-based contracting process to eCMS in 2007. The Office of Acquisitions and Logistics implemented eCMS, as VA's mandatory contract processing system to promote uniformity in contracts, improve the consolidation of requirements, and provide a secure electronic archiving system.

*VA's Cost  
Savings  
Estimate*

We conducted two visits and several in-person interviews with staff who worked on the development, award, and administration of the PC3 contracts, including the:

- Deputy CBO for Purchased Care
- Purchased Care Office managers and staff
- PC3 contracting staff
- PC3 Contracting Officer Representatives

However, they could not provide the name of the individual or individuals that developed the cost savings estimate or provide reliable historical information and documentation regarding the development of VA's \$13 million cost savings estimate. After several unsuccessful efforts to identify and obtain support for the \$13 million cost savings from CBO and DALC staff, the CBO's office provided the following information in an email to the OIG.

*CBO Cost  
Savings  
Estimate Email  
June 20, 2014*

*Through the contracting process, the Department of Veterans Affairs (VA) was able to obtain rates based on Medicare and, when compared to general non-VA medical care rates, the PC3 rates are lower, thus enabling cost avoidance.*

*The PC3 contracts are Indefinite Delivery/Indefinite Quantity type contracts with negotiated prices for the covered services based on Medicare. Each contractor has specific proprietary rates for each region. The total cost to VA for this care consists of this price for the covered service, the cost of the contractors administration of their provider networks to VA standards (administrative fee), and the cost of initial set up of the provider networks (implementation fee). The negotiated rates for each of these three elements differ for each region, contractor, and are procurement sensitive. The projected cost avoidance increases as the PC3 Program is utilized in lieu of general non-VA medical care.*



*The budget submission called for \$39 million in total cost avoidance from FY14-FY16. This figure is based on an anticipated PC3 utilization rate between 25-50% over that time. Before the contract award was made, we developed a tool to estimate cost avoidance at different utilization rates. Because that document is considered procurement sensitive, it can only be released by the contracting officer...*

After we received this email, we obtained the tool referenced in the email from the contracting officer. We determined that the PC3 Tool required the user to input an expected "utilization rate" for each of VA's six PC3 provider network regions. The utilization rate represented the expected number of PC3 authorizations issued during the fiscal year expressed as a percentage of the total number of non-VA care authorizations. Since the PC3 Tool we received did not identify the specific utilization rates needed to develop a \$39 million savings or average annual \$13 million cost savings estimate, we could only use it to hypothesize what utilization rates between 25 and 50 percent VA staff input for the six PC3 network regions to develop the cost savings estimate.

We eventually found a DALC Best Value Award Decision document in eCMS that showed the following projected annualized cost savings at various utilization rates (rounded):

- \$8.6 million cost savings at a 25 percent utilization rate
- \$21.9 million cost savings at a 50 percent utilization rate
- \$35.2 million cost savings at a 75 utilization rate
- \$48.8 million cost savings at a 100 percent utilization rate

However, the award decision document also did not provide the utilization rates used to obtain the estimated average annual \$13 million cost savings estimate. In addition, the document did not identify who prepared the cost savings estimates, the source of the projections, how the projections were developed, or provide supporting data for the projections. The award decision document simply stated that the cost savings estimates were based on a comparison of contracted costs with historical fee based costs. Based on the savings presented in the Best Value Award Decision, we estimated VA would have had to achieve a utilization rate between approximately 59 and 63 percent to achieve the \$13 million projected cost savings and recoup about \$14.7 million in implementation fees paid to the PC3 contractors in FY 2014.

To only recoup the \$14.7 million in fees paid to the PC3 contractors, the Purchased Care Office's PC3 Tool indicated that VA medical facilities in all six PC3 regions would have had to achieve approximately a 40 percent utilization rate. The 40 percent utilization rate was well above VA's

FY 2014 national PC3 utilization rate of about 9 percent (125,000 PC3 authorizations divided by 1.4 million non-VA care authorizations). VA's achievement of a 40 percent utilization rate seemed overly optimistic since the utilization rate of Project HERO, the model for the PC3 initiative, only managed a 16.4 percent utilization rate for health care services over the project period, FY 2009 through FY 2012. In our opinion, projecting a higher utilization rate under the PC3 contracts given Project HERO's low 16.4 percent utilization rate was unrealistic.

**Basic  
Underlying  
Assumption  
for PC3  
Contracts**

The basic underlying assumption of the PC3 contracts is that the accrued cost savings for PC3 health care services will more than offset the contractors' fees since the negotiated PC3 contract rates are generally lower (with the exception of Alaska's rates) than the Medicare rates VA typically pays for non-VA care. Further, VA presumes that its PC3 cost avoidance or savings will increase as VA medical facilities increase their use of PC3 contracts and decrease their use of individual authorizations to purchase non-VA care services.

We question the reasonableness of VA's assumption that the PC3 contractors could develop an adequate network of specialized providers with contract rates lower than Medicare rates and that it could achieve the utilization rates necessary to meet the cost savings estimates presented in its Budget Submission. VA lacked a specific PC3 implementation plan to ensure VA medical facilities achieved the 25 to 50 percent utilization rates used in the development of VA's cost savings estimate. In our opinion, VA needed a PC3 implementation plan to ensure its medical facilities made a strong, coordinated effort to achieve these utilization rates over the life of the PC3 contracts because Project HERO only achieved a 16.4 percent utilization rate over 4 years. At the same time, we found evidence that significant PC3 contract performance problems contributed to VA medical facilities' low PC3 utilization rate of approximately 9 percent in FY 2014.

- Neither PC3 contractor had established adequate provider networks. The PC3 contracts required full implementation of the networks in all six provider network regions by April 2014. However, the PC3 Contracting Officer issued corrective action letters faulting the respective contractors for inadequate provider networks in February, May, and September 2014.
- CBO's PC3 site visit reports from February through September 2014 cited VA medical facility concerns regarding the adequacy of the PC3 networks, including one VA medical facility that requested a pause in its use of PC3.
- At one VA medical facility, staff stated they only authorized non-urgent care such as ophthalmology under PC3 because they could not rely on the PC3 contractor to schedule appointments for other medical services due to a shortage in network providers.

- Non-VA care authorization staff at the same facility also stated that PC3 contractors returned authorizations because a lack of network providers. This resulted in the need to reauthorize care under the non-VA care program and caused additional delays in veterans' care.

### **Conclusion**

We could not attest to the reliability and accuracy of VA's PC3 cost savings estimate for FY 2014. The absence of documentation and reliable cost savings estimate information after we interviewed VA officials responsible for awarding and implementing the PC3 contracts prevented us from validating the methodology and calculations used to develop the \$13 million cost savings estimate.

Further, cost comparisons we performed indicated that it cost more to purchase services through PC3 contracts than non-VA care in FY 2014 due to the PC3 contracts' implementation fees. VA's inadequate price analysis, high up-front contract implementation fees, and low PC3 utilization rates also impeded VA from achieving its \$13 million PC3 cost saving estimate in FY 2014. In light of the serious issues identified during this review, we have initiated a series of projects to evaluate the extent PC3 contract performance issues are affecting veterans' access to non-VA provided health care services.

### **Recommendations**

1. We recommended the Interim Under Secretary for Health assign an accountable senior executive to prepare and document revised Patient-Centered Community Care price analyses and determine if VA will realize any cost savings during the future option years of the contracts.
2. We recommended the Interim Under Secretary for Health develop an action plan to address low PC3 contract utilization rates.
3. We recommended the Executive Director, Office of Acquisition, Logistics, and Construction ensure all required contract documents are maintained in the official Patient-Centered Community Care contract files in accordance with Federal Acquisition Regulation and hold the contracting officer accountable for ensuring complete and accurate information is maintained in the Electronic Contract Management System.

### **Management Comments**

The Interim Under Secretary for Health agreed with our findings and recommendations and plans to address our recommendations by February 28, 2016. Under the direction of the Chief Business Officer and Deputy Chief Business Officer Purchased Care, VHA will develop a new cost analysis to provide a more current and accurate estimate of cost savings realized through PC3 contracts.

VHA's Chief Business Office will also develop an action plan that addresses PC3 utilization rates by identifying sites with low PC3 usage, high percentage of appointments scheduled greater than 30 days, and high electronic waiting list counts. This plan will further delineate specific outreach and actions designed to increase those sites' utilization of PC3.

The Executive Director, Office of Acquisition, Logistics, and Construction agreed with our findings and recommendations and plans to address our recommendation by June 15, 2015. The Executive Director will ensure all required PC3 contract documents are included in the eCMS briefcase, to include repopulating all files as appropriate, and will take appropriate action if the contracting officer is found accountable for not maintaining the contract files in eCMS according to policy.

***OIG Response***

The Interim Under Secretary of Health and the Executive Director, Office of Acquisition, Logistics, and Construction provided a responsive action plan and comments to address our recommendations. We will monitor the VA's progress and follow up on its implementation until all proposed actions are completed.

## Appendix A Background

### **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 non-VA care 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 non-VA care 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 non-VA care. 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 provides eligible veterans access to:

- Primary care<sup>2</sup>
- Inpatient and outpatient specialty care
- Mental health care
- Limited emergency care
- Limited newborn care for enrolled female veterans following delivery

### **Project HERO**

Project HERO served as the model for PC3. Project HERO provided veterans contracted specialty and dental care in four Veterans Integrated Service Networks (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, to 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

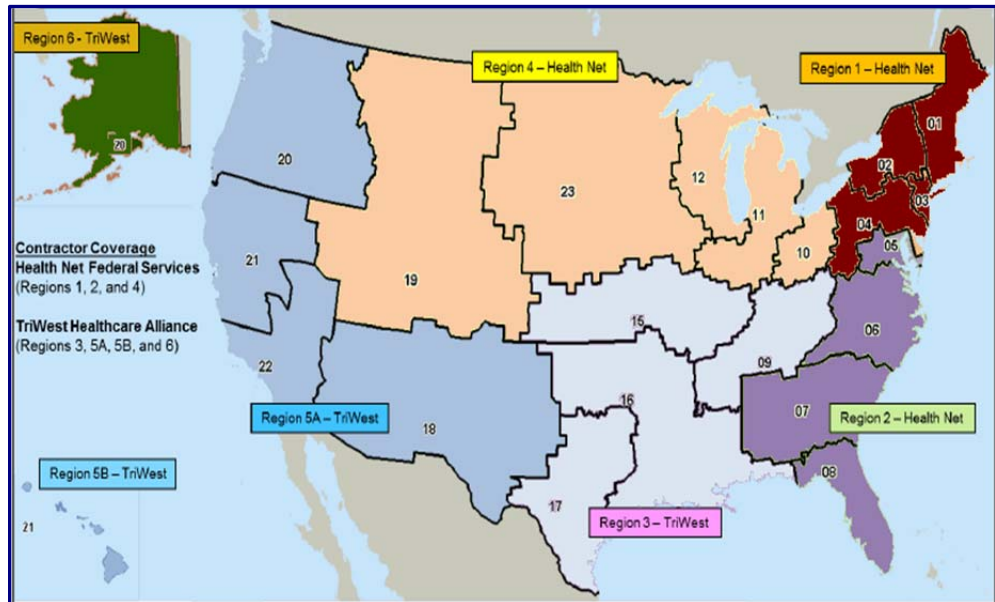
<sup>2</sup> VA modified the PC3 contracts on August 8, 2014, to add primary care.

highly rural areas. Project HERO did not place limits on the distance veterans traveled to obtain services.

**PC3  
Contractors**

In September 2013, VA awarded Health Net Federal Services, LLC and TriWest Healthcare Alliance Corp. 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 1 shows the contractors' PC3 regions.

**Figure 1: Map of PC3 Regions**



Source: CBO PC3 Intranet Site; 8:00 a.m.; December 8, 2014

VA evaluates the PC3 contractors' performance based on elements in the Quality Assurance and Surveillance Plan, 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 Quality Assurance and Surveillance Plan.

**Program  
Office**

VHA's CBO oversees the development of administrative processes, policy, regulations, and directives for the delivery of VA health care benefits programs to veterans. The Purchased Care Office is responsible for programs, such as non-VA care (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 (PMO) to oversee the PC3 program. The PMO for the PC3 contracts perform outreach at the VISNs and VA medical facilities to answer questions about PC3 and gain an understanding of the users' needs.

## Appendix B Scope and Methodology

### *Scope*

We conducted our review from June 2014 through December 2014. The review focused on the population of disbursed FY 2014 PC3 payments made for authorizations and implementation and administrative fees. We obtained the data from CBO's POI and the Contracting Officer's Representatives.

### *Methodology*

To accomplish our objectives, we reviewed applicable laws, regulations, policies, procedures, and guidelines. We also interviewed appropriate management and employees. To determine how VA derived the \$13 million PC3 cost savings estimate, we contacted the CBO and DALC to request supporting documentation. After several efforts to locate supporting documents yielded no results, the Executive Assistant to the Deputy for the Purchased Care Office sent us a brief email in response to our final document request. The email provided a general explanation for the calculation of the cost savings estimate and mentioned that the PC3 Contracting Officer had a PC3 Tool that was developed prior to the contract award.

We analyzed the PC3 Tool and the information provided by the Purchased Care Office and found that the tool used embedded formulas and pre-populated data to:

- Estimate the number and type of PC3 authorizations each region would issue during the fiscal year and the related costs for the services based on the entered utilization rates.
- Total the estimated fiscal year PC3 health care service costs and PC3 administrative fees for each region.
- Subtract the total PC3 health care service costs and administrative fees from the estimated non-VA care costs for comparable health care services, thus, calculating an estimated PC3 contract cost savings by region.
- Reduce the estimated PC3 contract cost savings by the contracts' fixed implementation fees.

We also compared the amount VA spent to procure health care services under PC3 with the estimated amount VA would have paid for the same services using non-VA care to identify possible cost savings. VA essentially used Medicare rates as the benchmark for its non-VA care costs when it established the PC3 contracts. Hence, we used the 100 percent Medicare rate to estimate what the costs of the purchased PC3 health care services would have been if they had been purchased under the non-VA care program.

Since the PC3 medical and surgical service contract line item prices for all of the PC3 regions, except Alaska, were negotiated as a fixed percentage below



the Medicare rate<sup>3</sup>, we divided the cost of the purchased PC3 services by the appropriate clinical line item percentage (fixed percentage below Medicare) to obtain the cost of the services at the 100 percent Medicare rate, the estimated non-VA care cost. We compared the non-VA care and PC3 costs for the same services to calculate any potential cost savings from the use of PC3 and then subtracted the additional PC3 contract costs (implementation and administrative fees) VA paid in FY 2014.

**Data  
Reliability**

We also obtained computer-processed data from VA's Corporate Data Warehouse to identify VA's FY 2014 PC3 authorizations and expenditures. To test the reliability of this 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. However, we could not attest to the reliability and accuracy of VA information regarding the methodology and calculation of the PC3 cost savings estimate. The Purchased Care Office lacked corroborating and supporting evidence for the cost savings estimate. Further, we could not verify the accuracy of the data in the PC3 Tool's spreadsheets, ensure the reasonableness of the assumptions used by the PC3 Tool to develop the cost savings estimates, or even ensure VA staff had used the PC3 Tool to develop VA's cost saving estimate projections and Budget Submission.

**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.

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<sup>3</sup> For Alaska, the non-VA care and PC3 prices both exceeded the 100 percent Medicare rate by a set percentage although the negotiated PC3 rates were lower. Hence, we divided the PC3 costs by the PC3 percentage above Medicare to obtain the cost of the services at the 100 percent Medicare rate and then multiplied these costs by the non-VA care percentage above Medicare to calculate the cost of the services under non-VA care.



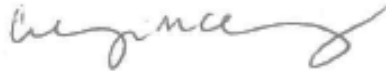
## Appendix C Interim Under Secretary for Health Comments

### Department of Veterans Affairs

### Memorandum

**Date:** April 17, 2015  
**From:** Interim Under Secretary for Health (10)  
**Subj:** OIG Draft Report, Review of VA's Patient-Centered Community Care (PC3)  
Contracts' Estimated Cost Savings  
**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 and 2.
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.



Carolyn M. Clancy, M.D

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)  
Action Plan

OIG Draft Report, Review of VA's Patient-Centered Community Care (PC3) Contracts'  
Estimated Cost Savings

Date of Draft Report: March 18, 2015

Recommendations/ Actions	Status	Completion Date
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**Recommendation 1.** We recommended the Interim Under Secretary for Health assign an accountable senior executive to prepare and document revised Patient-Centered Community Care price analyses and determine if VA will realize any cost savings during the future option years of the contracts.

VHA Comments: Concur. Under the direction of the Chief Business Officer and Deputy Chief Business Officer Purchased Care, a new cost analysis will be developed to provide a more current and accurate estimate of cost savings realized through the PC3 contracts.

<b>Status:</b> In process	<b>Target Completion Date:</b> Feb. 28, 2016
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**Recommendation 2.** We recommended the Interim Under Secretary for Health develop an action plan to address low PC3 contract utilization rates.

VHA Comments: Concur. The Chief Business Office will develop an action plan to address PC3 utilization rates. The plan will identify sites with low PC3 usage, a high percentage of appointments scheduled greater than 30 days, and a high electronic waiting list count. The plan will further delineate specific outreach and actions designed to increase those sites' utilization of PC3.

<b>Status:</b> In process	<b>Target Completion Date:</b> Sept. 30, 2015
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Veterans Health Administration  
April 2015

## Appendix D Executive Director, Office of Acquisition, Logistics, and Construction Comments

### Department of Veterans Affairs

### Memorandum

**Date:** April 23, 2015

**From:** Executive Director, Office of Acquisition, Logistics, and Construction (003)

**Subj:** OIG Draft Report: Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings (VAIQ No. 7590678)

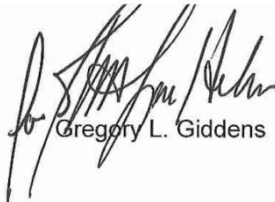
**To:** Assistant Inspector General for Audits and Evaluations (52A)

1. The Assistant Inspector General for Audits and Evaluations requested comments on the findings and recommendations in the draft report, "Review of VA's Patient-Centered Community Care (PC3) Contracts' Estimated Cost Savings," to review VA's costs as they relate to the budget submission stated potential savings of \$13 million.
2. The Office of Acquisition, Logistics, and Construction (OALC) has completed its review of the draft report. OALC concurs with Recommendation 3, and has provided some input to the Interim Under Secretary for Health to assist with their responses to Recommendations 1 and 2. OALC provides the following comments.

**Recommendation 3:** We recommended the Executive Director, Office of Acquisition, Logistics, and Construction ensure all required contract documents are maintained in the official Patient-Centered Community Care contract files in accordance with Federal Acquisition Regulation and hold the contracting officer accountable for ensuring complete and accurate information is maintained in the Electronic Contract Management System.

**OALC Response:** Concur. OALC agrees that all required contract documents are to be maintained in the Electronic Contract Management System (eCMS) briefcase, and all files will be repopulated, as appropriate. Additionally, appropriate action will be taken if the contracting officer is found accountable for not maintaining the contract files in eCMS according to policy. **Estimated completion date: June 15, 2015.**

3. Should you have any questions regarding this submission, please contact Shana Love Holmon, OALC Chief of Staff, at (202) 632-4606 or [shana.love-holmon@va.gov](mailto:shana.love-holmon@va.gov).



Gregory L. Giddens

## **Appendix E Office of Inspector General Contact and Staff Acknowledgments**

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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 Gregory Gladhill Herlin Guerra-Sagastume Sunny Lei Andrea Lui Andrea Sandoval
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