

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



# Department of Veterans Affairs

*Review of  
the Award of  
the Patient-Centered  
Community Care (PC3)  
Contracts*

September 22, 2016  
15-01396-525

# ACRONYMS

CBO	Chief Business Office
CO	Contracting Officer
COR	Contracting Officer's Representative
DALC	Denver Acquisition and Logistics Center
DoD	Department of Defense
eCMS	Electronic Contract Management System
FAR	Federal Acquisition Regulation
HN	Health Net Federal Services, Limited Liability Corporation
IGCE	Independent Government Cost Estimate
IPT	Integrated Product Team
NVC	Non-VA Care
OALC	Office of Acquisition, Logistics, and Construction
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
TET	Technical Evaluation Team
TW	TriWest Healthcare Alliance Corporation
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

**To report suspected wrongdoing in VA programs and operations,  
contact the VA OIG Hotline:**

**Web Site: [www.va.gov/oig/hotline](http://www.va.gov/oig/hotline)**

**Email: [vaoighotline@va.gov](mailto:vaoighotline@va.gov)**

**Telephone: 1-800-488-8244**



# Highlights: Review of VA's Award of the PC3 Contracts

## Why We Did This Review

We reviewed Department of Veterans Affairs (VA) Patient-Centered Community Care (PC3) contracts to determine whether they were adequately developed and awarded. In September 2013, VA awarded the PC3 contracts to provide veterans with a comprehensive, nationwide network of high-quality, specialty health care services. The contracts were awarded for an estimated \$9.4 billion, with a potential cost to VA of \$27 billion.

## What We Found

We found significant weaknesses in the planning, evaluation, and award of the PC3 contracts. The PC3 contracts were not developed or awarded in accordance with acquisition regulations and VA policy intended to ensure services acquired are based on need and at fair and reasonable prices. The contracting officials solicited proposals from vendors without clearly articulating VA's requirements. Thus, the vendors bidding on the solicitation did not have sufficient information on the type of specialty health care services they would need to provide, where to provide them, and the frequency. Therefore, VA increased the risk of not achieving the objectives of PC3 by inadequately identifying its health care service requirements.

We found that documentation supporting vital contract award decisions was either not in VA's Electronic Contract Management System or incomplete. Of the documents available, we noted that the awarded costs were actually negotiated at a higher rate than originally proposed by one of the vendors. The evidence for these decisions was not

documented in the price negotiation memo. Accountability for ensuring the effective award of these contracts was not vested with a senior executive at VA. Although the contracting officer had the authority to execute these contracts, the level of oversight for this degree of contract risk did not provide reasonable assurance that VA's interests were adequately protected.

The Veterans Access, Choice, and Accountability Act of 2014 (Choice) was enacted on August 7, 2014. According to VA's Under Secretary for Health in a memo dated July 7, 2016, since implementing the Hierarchy of Care memorandum in May 2015, the use of Choice has increased tremendously, while PC3 use has dwindled.

## What We Recommended

We recommended the Principal Executive Director for Acquisition, Logistics, and Construction improve oversight and accountability, and ensure sufficient planning on all high-dollar value and complex acquisitions.

## Agency Comments

The Principal Executive Director concurred with our recommendations and provided technical comments. An acceptable corrective action plan was provided and we will follow up on its implementation.

A handwritten signature in black ink that reads "Larry M. Reinkemeyer".

**LARRY M. REINKEMEYER**  
Assistant Inspector General  
for Audits and Evaluations

# TABLE OF CONTENTS

Introduction.....	1	
Results and Recommendation.....	2	
Finding	VA’s Patient-Centered Community Care Contracts Were Not Adequately Developed and Awarded to Enable Effective Implementation and Monitoring of the Intended Services.....	2
	Recommendations .....	12
Appendix A	Potential Monetary Benefits in Accordance With Inspector General Act Amendments .....	14
Appendix B	Management’s Comments.....	15
Appendix C	OIG Contact and Staff Acknowledgments.....	18
Appendix D	Report Distribution .....	19

## INTRODUCTION

### **Objective**

Our objective was to determine whether VA's Patient-Centered Community Care (PC3) contracts were adequately developed and awarded. These contracts were awarded to provide a comprehensive, nationwide network of high-quality, specialty health care services for veterans.

### **What We Did**

The Office of Inspector General (OIG) conducted the review from December 2014 through August 2015. To accomplish the objective, we reviewed applicable acquisition regulations and VA policies. We also reviewed contract documents, such as the acquisition plan, independent government cost estimate (IGCE), solicitation, contractor technical evaluation, and price proposals, located within VA's electronic contract management system (eCMS) and other documents provided by acquisition officials. We also interviewed various PC3 acquisition officials.

### **Background**

VA awarded these contracts as a 1-year base period and four 1-year option periods, under the authority of Section 8153, Title 38, United States Code, *Sharing of Health-Care Resources*. This law allows the Veterans Health Administration (VHA) to enter into contracts with non-VA health care providers. VA's Denver Acquisition and Logistics Center (DALC), under the National Acquisition Center, provided contracting support to VHA's Chief Business Office (CBO) for the PC3 contracts. DALC negotiated and awarded PC3 contracts to two contractors, Health Net Federal Services, Limited Liability Corporation (HN) and TriWest Healthcare Alliance Corporation (TW), in September 2013.<sup>1</sup>

The service contract awards amounted to an estimated \$9.4 billion. These contracts were negotiated as firm-fixed-price, indefinite-delivery, indefinite-quantity contracts. Including the start-up and the maximum dollar value for the additional option years, the total potential cost to VA for these contracts was estimated at \$27 billion.

### **Veterans Access, Choice, and Accountability Act**

The Veterans Access, Choice, and Accountability Act of 2014 (Choice) was enacted on August 7, 2014. According to VA's Under Secretary for Health in a memo dated July 7, 2016, since implementing the Hierarchy of Care memorandum in May 2015, the use of Choice has increased tremendously, while PC3 use has dwindled.

---

<sup>1</sup> *Review of VA's Patient-Centered Community Care Contracts' Estimated Costs Savings*, Report No. 14-02916-336, April 28, 2015, *Review of Alleged Delays in Care Caused by Patient-Centered Community Care Issues*, Report No. 14-04116-408, July 1, 2015, *Review of Patient-Centered Community Care Provider Network Adequacy*, Report No. 15-00718-507, September 29, 2015, and *Review of Patient-Centered Community Care Health Record Coordination*, Report No. 15-00574-501, September 30, 2015

## RESULTS AND RECOMMENDATIONS

### **Finding**      **VA's Patient-Centered Community Care Contracts Were Not Adequately Developed and Awarded to Enable Effective Implementation and Monitoring of the Intended Services**

#### ***What We Found***

PC3 contracts were not adequately developed and awarded. Numerous significant weaknesses were identified in the key acquisition phases leading up to the award of two PC3 contracts with an estimated total value of \$27 billion. The acquisition team failed to comply with Federal and VA acquisition regulations and VA policies. These regulations and policies ensure services acquired by VA are based on verifiable needs and at fair and reasonable prices.

The documentation supporting vital contract award decisions in the planning, evaluation, and award phases was either not in the official contract file (eCMS) or was incomplete. Our review attributed these weaknesses to the acquisition team's inadequate planning and oversight by VA acquisition leadership. These weaknesses increase the risk that the PC3 contracts were not in the best interest of the Government, and reduce assurance that veterans will be consistently provided with needed health care services.

#### ***Weaknesses in the Planning Phase***

During the acquisition planning phase, critical actions are performed such as establishing the requirements, conducting market research, and developing the IGCE. These actions and accompanying decisions establish the foundation for the entire acquisition and should be documented in the acquisition plan.

The purpose of acquisition planning is to identify the specific work to be accomplished and provide objective measures to monitor the work performed, so the Government can meet its needs in the most effective, economical, and timely manner. A lack of fully developed requirements can lead to risk, or burden, to the Government to provide the appropriate health care services to veterans.

The original scope of work for PC3 explicitly excluded primary care. Primary care services were subsequently added to the two contracts via modifications. Consequently, the addition of these services after award was outside of the PC3 contracts' initial scope of work.

#### ***Network Requirements Not Identified***

The acquisition team did not identify the health care services VA medical facilities had historically purchased by veteran or provider location (for example, ZIP code). This was critical information that would need to be included in the solicitation. This information would have provided the basis

for identifying responsible prospective contractors and assessing and monitoring the contractors' ability to deliver and maintain adequate provider networks. The acquisition team's failure to identify this critical information and to develop an adequate acquisition plan and perform sufficient market research in accordance with applicable acquisition regulations and VA policies posed significant risks to the PC3 initiative achieving its intended results.

In 2011, a management consultant firm conducted an independent review of Healthcare Effectiveness through the Resource Optimization Project (Project HERO)—this was the model for PC3.<sup>2</sup> The consultants reported that one of Project HERO's weaknesses was that VHA had not clearly determined the number of physicians it needed by specialty to meet the anticipated demand for services. Despite this report's recommendation, CBO did not develop provider network requirements detailing VHA's specific demands and needs for non-VA health care (NVC) services as part of the acquisition planning for PC3.

CBO and contracting staff stated that the PC3 contract only contained summary-level national NVC data and patient enrollment data. They claimed that they did not have the necessary historical VA medical facility NVC data by location and could not forecast national demands for health care services. Despite the CBO and contracting staff's assertions that this information was not available at the time of the PC3 contract award, we identified VHA information sources that provided detailed breakdowns of veterans' health care information by VA medical facility. Data files in VHA's Support Service Center contained NVC information such as:

- Veterans' ZIP codes
- Procedure and diagnosis codes
- Veterans area designation (urban, rural, or highly rural)

Reports containing these data for all VA medical facilities have been available through VHA's Support Service Center Enrollment and NVC Data Cubes since November 2007. NVC data could have provided prospective contractors much more useful information on the types of services veterans needed and the locations where they were needed compared to the summary level data included in the solicitation. However, none of this information was used by the acquisition team.

*Market  
Research  
Not Adequate*

Market research is conducted to arrive at the most suitable approach to acquiring, distributing, and supporting required services, and to identify qualified contractors. While some aspects of the PC3 market research report

<sup>2</sup> *VHA Project HERO Contracted Healthcare Comparative Assessment*, Corrigo Health Care Solutions, LLC, November 4, 2011.

were met, the results were not well-documented to draw the conclusion that the requirements were valid and that there were sufficient contractors who could perform the requirements.

*IGCE Not  
Documented  
Properly*

The IGCE is used to establish a realistic price for goods and services for budgetary and negotiation purposes. The IGCE should adjust for any changes in specifications, quantities, or inflation factors for a contract with option years.

While we obtained several different versions of the IGCEs before the award of the PC3 contract, we did not locate a signed or final version of the document in eCMS. The PC3 IGCEs did not include inflation of pricing for the four option years, which would be inherent for any multi-year system for health care services. In addition, PC3 divided the United States into six geographic regions to ensure consideration of the health care demographics and the cost-of-living differential for each of these regions. However, the cost estimates for some of the services in each of these regions did not account for these geographic cost-of-living considerations as the IGCEs were exactly the same.

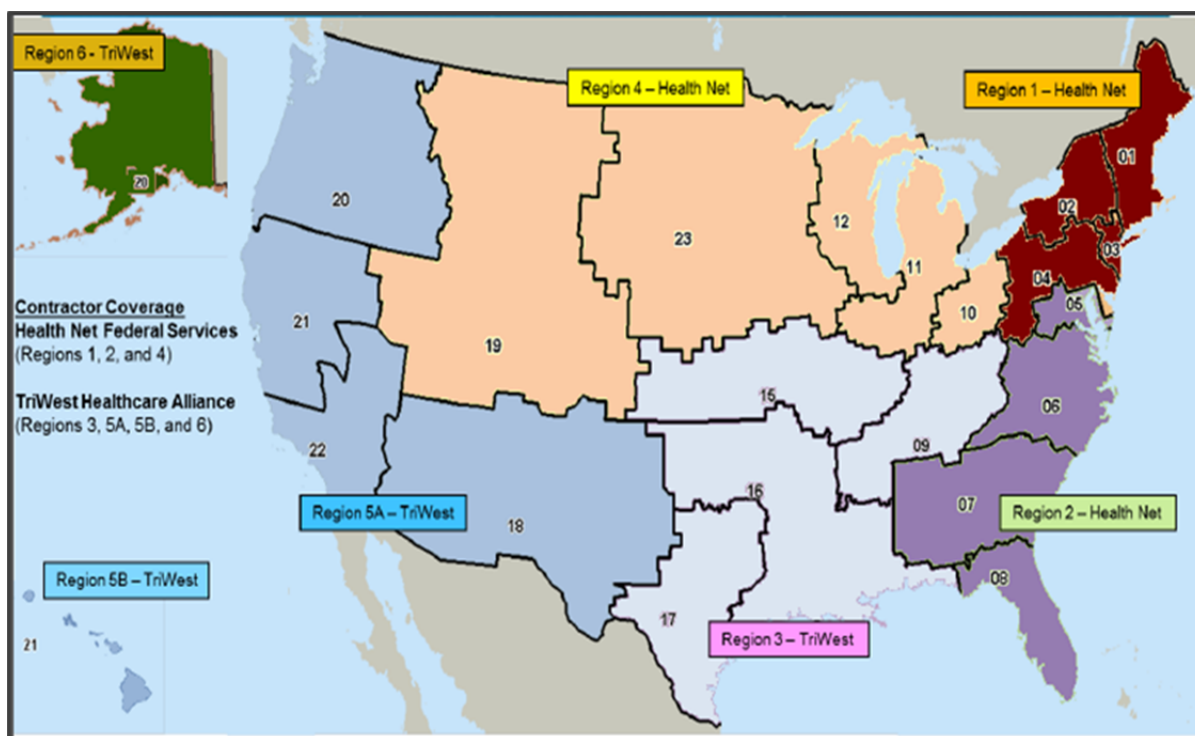
These critical planning actions—the requirements, market research, and IGCE—should be the foundation of the acquisition process and should be documented in the acquisition plan. Although the acquisition team developed a written acquisition plan, critical steps were either not performed or inadequately documented. As a result, the plan did not comply with applicable acquisition regulations and VA policies. These key planning elements are the basis of the solicitation.

*Solicitation  
Not  
Documented  
Properly*

The solicitation phase is the next key acquisition process. During the solicitation phase, important actions, such as selecting an appropriate contract type and developing solicitation documents, are performed. The goal when issuing a solicitation in a competitive environment is to receive multiple proposals from a variety of contractors who have the potential of providing the requested services. The PC3 acquisition team divided the United States into six geographic regions and solicited proposals for specialty health care in each.



**Figure. PC3's Six Geographic Regions To Provide Comprehensive, Nationwide Networks of High-Quality, Specialty Health Care Services for Veterans**



Source: CBO PC3 Intranet Site

The solicitation did not include sufficient historical NVC data and forecasts of the future demand for NVC services so that PC3 contract bidders had adequate information. PC3 contract bidders reportedly communicated to contracting staff that they needed data on the types of services and procedures VA medical facilities had historically purchased and locations where the services had been provided based on either the veterans' or provider's ZIP codes.

The PC3 solicitation only provided summarized data, from FY 2010 through FY 2012, on NVC purchases, the count of outpatient visits, and veteran enrollment by ZIP code, which would identify urban, rural, or highly rural locations. The absence of sufficiently detailed historical data, identifying and linking the specific services purchased with the locations where they were provided, meant prospective bidders found it extremely difficult to establish provider networks with the necessary number and mix of health care providers in the geographic locations where veterans needed them.

The HN and TW executives we interviewed indicated that VA did not provide the necessary information needed to plan the PC3 provider networks and establish adequate provider networks in mainly rural, highly rural, and historically underserved locations during the solicitation. The executives reportedly expressed these concerns to contracting staff and requested additional information regarding veterans' geographic location by ZIP code,

the specific specialty care purchased, and medical facility level reports showing its active NVC providers and its specialties, to estimate the number of needed providers. They stated that more targeted data during the planning phase would have been useful as the demand for services were unknown and were being learned as actual requests for care were received. They also stated that the contracting staff told them this information was unavailable and directed them to the NVC and veteran data in the solicitation.

***Weaknesses  
in the  
Evaluation  
Phase***

The evaluation phase starts when vendors' proposals are received. These proposals describe how the contractor would accomplish the work required through its technical abilities, past performance in completing similar work, and its proposed prices. A technical evaluation team and a pricing team evaluate the proposals. The technical team evaluates the proposals according to the requirements of the solicitation and the pricing evaluation team verifies and validates the reasonableness of the proposed prices.

***Insufficient  
Competition***

The incumbent for Project HERO (Humana) informed the DALC acquisition team that it would not be submitting a proposal on the PC3 solicitation. A primary reason for Humana's decision was concerns with the solicitation, such as the lack of data on projected variety and volume of specialty care authorizations, regional pricing, and barriers to utilization of PC3 by VHA. Although VA attempted to address these concerns with amendments to the solicitation, the acquisition team only received two proposals for an estimated \$27 billion in contracts. HN submitted a proposal for Regions 1 and 4 and TW submitted a proposal for Region 5. No proposals were received for Regions 2, 3 or 6. After negotiations, the acquisition team contacted HN and TW, requesting pricing for the remaining regions. HN provided pricing for Region 2, while TW provided pricing for Regions 3 and 6. Because only one proposal for each Region (2, 3, and 6) was received, the acquisition team did not obtain competitive bids.

In comparison, the Department of Defense's (DoD) TRICARE is a health care program that supported nearly 9.7 million service members, retirees, and their families in fiscal year 2012. When DoD solicited its contract in 2008, according to a Government Accountability Office (GAO) Report to the Senate Committee on Armed Services, dated March 2014, it received proposals from six contractors. There were two or three proposals received for each of the three regions specified in DoD's contract.

***Technical  
Evaluation***

Though the DALC acquisition team did not receive competitive bids for Regions 2, 3, or 6, the acquisition team initiated the evaluation of the proposals received. Contracting staff, in conjunction with the PC3 technical evaluation team (TET), did not complete adequate responsibility determinations for HN and TW, as required by the Federal Acquisition

Regulation (FAR) 9.103.<sup>3</sup> This occurred because contracting staff and the TET lacked objective information to assess the adequacy of the contractors' existing provider networks and its ability to build provider networks to meet VA's needs. FAR 9.104 requires responsible contractors to meet the following minimum requirements:

- Have adequate financial resources to perform the contract, or the ability to obtain them
- Be able to comply with the required or proposed delivery or performance schedule

The TET used three equally weighted factors: management approach, network development and maintenance, and corporate experience/capability, to evaluate HN's technical proposal for Regions 1 and 4 and TW's technical proposal for Region 5.

To address the network development and maintenance factor, contractors were required to include information on the number and locations of current health care providers. The proposals also needed to address how a contractor would determine the need for future network providers, based on the historical purchased care data provided by VA. The TET rated both HN and TW "Highly Acceptable," the second highest rating available, in this factor.

Although the TET gave both HN and TW "Highly Acceptable" ratings for network development and maintenance, the TET lacked adequate historical purchased care data by location to identify what services were needed and where. The proposals did not clearly indicate the health care specialties or specify the locations where they were needed. Without this information, the TET lacked objective means to determine if the two contractors could at least provide the same health care services the VA medical facilities purchased through the non-VA health care program.

Without objective analyses and forecasts of the amount and types of care VHA needed in the six PC3 regions, the TET essentially relied on the contractors' self-assessments of what VA's needs were, based on the data provided in the solicitation. In effect, VA's contracting officer (CO) and the TET for this contract allowed the contractors themselves to assess VA's needs and present how those needs would be met. Reliance on the contractors' interpretation and assessment of VA's needs based on the limited information provided in the solicitation did not sufficiently protect the Government's and VA's contractual interests.

---

<sup>3</sup>The TET consisted of representatives from VHA inter-disciplinary patient care services such as CBO, VHA Patient Care Services, and VHA Office of Quality, Safety, and Value.

Pricing  
Evaluation

We identified a significant weakness during the evaluation of the pricing proposals. Specifically, the Best Value Award Decision document did not contain sufficient information to explain adequately how the proposed prices were fair and reasonable to the Government. The price analysis language in this document references an ICGE and price evaluation worksheet, which were used to help determine price reasonableness. However, we were not able to locate these documents in the contract file. There was an evaluation matrix in the contract file, but the matrix did not contain price evaluation information. The matrix only included information regarding past performance and socio-economic consideration. Without the evidence to be able to duplicate the process, we were unable to gain reasonable assurance of fair and reasonable pricing at the time of award.

In the few documents available, we noted that the actual awarded costs for the administration service fees were negotiated at a higher rate than originally proposed by HN, as illustrated in Tables 1 and 2. For example, in Region 1, HN estimated just over \$1.1 million in fees, but the acquisition team ended up awarding the base-year fee amount of over \$1.2 million. In effect, the acquisition team increased the potential cost of the HN contract by over \$16.8 million (approximately \$3.8 million in Region 1 and approximately \$13 million in Region 4). Although required by FAR 15.406, the rationale behind the increases for tiers 2 and 3 were not documented in the price negotiation memo.

**Table 1. HN's Proposed Administrative Service Fees for Region 1**

	<b>HN's Proposed Fee</b>	<b>HN's Awarded Fee</b>	<b>Differences in Fee Amounts</b>
Base Year	\$1,101,163.83	\$1,271,025.00	<b>\$169,861.17</b>
Option 1	1,711,187.60	2,540,999.70	<b>829,812.10</b>
Option 2	1,722,182.23	2,617,168.99	<b>894,986.76</b>
Option 3	1,786,577.36	2,695,600.74	<b>909,023.38</b>
Option 4	1,820,720.30	2,776,701.01	<b>955,980.71</b>
<b>Total</b>	<b>\$8,141,831.32</b>	<b>\$11,901,495.44</b>	<b>\$3,759,664.12</b>

*Source: OIG Calculation Based on Award Pricing Documentation*

**Table 2. HN's Proposed Administrative Service Fees for Region 4**

	<b>HN's Proposed Fee</b>	<b>HN's Awarded Fee</b>	<b>Differences in Fee Amounts</b>
Base Year	\$2,981,767.58	\$3,761,940.00	<b>\$780,172.42</b>
Option 1	5,040,027.59	7,669,194.60	<b>2,629,167.01</b>
Option 2	4,940,887.65	7,899,230.81	<b>2,958,343.16</b>
Option 3	4,881,301.65	8,135,894.92	<b>3,254,593.27</b>
Option 4	4,937,700.98	8,380,681.17	<b>3,442,980.19</b>
<b>Total</b>	<b>\$22,781,685.45</b>	<b>\$35,846,941.50</b>	<b>\$13,065,256.05</b>

*Source: OIG Calculation Based on Award Pricing Documentation*

Based on our review of the contract pricing, the contract pricing structure was set up on a 'tier-pricing' model. In this model, there is a cost saving based on volume discounts—as the number of patients served goes up, the cost per patient decreases in each tier. For PC3, the pricing per tier and number of patients per tier, change significantly. However, we noted that the acquisition team considered HN's proposed price per patient for the tier 1 as excessive.

The contracting officer engaged in negotiations over the pricing. The contractor submitted a revised proposal, lowering the prices for tier 1 patients, but increasing the prices for tiers 2 and 3, under which the greatest quantity of patients would be covered. The contracting officer did not address the changes to tiers 2 and 3, and accepted the contractor's revised proposal. While we did discuss this concern with the CO, and the CO stated she did consider the tiers, there was no documentation supporting the consideration in the official Price Negotiation Memorandum.

Based on our review of the Price Negotiation Memorandum, HN likely increased the prices for tier 2 and 3, in an effort to recoup profits lost after they were asked to lower the tier 1 prices. Had the VA acquisition team been diligent in its review of the entire pricing document, they would have noted that the new pricing model would actually cost VA more over the life of the PC3 contract. VA could have put this additional \$16.8 million to better use. Obtaining comprehensive price analysis assistance to ensure services are procured at fair and reasonable contract prices when negotiating high-dollar, complex service contracts could have been more fiscally responsible.

**Weaknesses  
in the Award  
Phase**

The award phase occurs after all evaluations have been performed, the required documentation has been prepared, and final reviews are completed by the contract review board. During this phase, the contractors and the Government sign an agreement on the requirements, price and quality, and establish roles and responsibilities.

The absence of sufficiently detailed historical data identifying and linking the specific services purchased with the locations where they were provided meant DALC could not assure that the awarded contracts had provider networks with the necessary number and mix of health care providers in the geographic locations where veterans needed them.

Thus, the PC3 contract documents did not provide sufficient information to determine whether the award decision was consistent with the terms and conditions established in the solicitation. We also determined that key contract documentation was not included in the contract file. The missing documentation included the signed contracts, contracting officer's representative (COR) delegation memos, and award notifications. These documents must be completed at the time of award, be provided to the contractor, and be included in the contract file in eCMS.

*Inadequate  
Quality  
Assurance  
Plan*

CBO and contracting staff did not develop an adequate quality assurance surveillance plan to determine whether they had a sufficient number and mix of health care providers in the geographic locations where veterans needed those services. The contract terms require quality assurance plans to be prepared in conjunction with contracts' statement of work during the contract award process. This enables the Government to perform contract quality assurance at such times and places as may be necessary.

*Lack of  
Effective  
Governance  
Structure*

Prior to award, VHA lacked an effective governance structure to provide the CBO the support and monitoring for the implementation of the acquisition of PC3. VHA did not ensure CBO properly planned, implemented, and monitored the PC3 acquisition process. The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* states that agency management needs to comprehensively identify risks and should consider all significant interactions between the agency and other parties, as well as internal factors at the activity level.

On June 1, 2011, 2 years prior to contract award, the previous VA Under Secretary for Health approved the PC3 initiative and simultaneously authorized the formation of the Integrated Product Team (IPT). The Deputy Chief Business Officer for Purchased Care, as the chair of the IPT, had primary responsibility for the governance of the PC3 initiative. The IPT, which comprised several senior VHA leaders and managers, also included workgroups of subject matter experts from across VA and VHA to develop PC3's program and contract requirements.

Despite VHA's well-intentioned plans to provide adequate senior leadership oversight during the development of the PC3 contracts, we found little evidence documenting the IPT's involvement in critical decision-making.

Accountability and oversight for ensuring the effective award of these contracts was not vested with a VA senior executive. Although the

contracting officer (who held an unlimited warrant) had the authority to execute these contracts, the level of oversight for this degree of contract risk did not provide reasonable assurance that VA's interests were adequately protected. VA's acquisition of PC3 did not require senior executive oversight comparable to other, less-costly programs.

For example, from January 2012 to May 2015, VA policy required the Secretary to approve any lease agreement entered into by VA, if it was over \$300,000. Also, VA's conference spending guidance requires senior executive-level oversight by requiring that any conference costing \$20,000 or more be reviewed by an Under or Assistant Secretary or equivalent. For PC3, the contracting officer, a GS-14, committed VA and the Government to a contract that is estimated at \$27 billion for 5 years. Based on these examples, the senior executive oversight and responsibility for this acquisition project was significantly under-emphasized.

**Failure  
To Document  
Key Acquisition  
Decisions  
in eCMS**

VA's failure to use eCMS, its electronic system of record for acquisitions, continues to be a significant weakness as noted in previous OIG reviews.<sup>4</sup> We provided the acquisition team with a list of missing documents from the eCMS contract file. In response, the contracting officer alleged that the contract files noted as missing from eCMS had been removed by "someone outside of the DALC." As a result of the contracting officer's allegations, the VA Central Office Enterprise Acquisition Services (EAS) and VA OIG Forensic IT teams reviewed the eCMS contract files to ascertain what contract files were removed and by whom. Their review determined only that the acquisition team had the ability to add or remove contract documents in eCMS.

**Conclusion**

The acquisition team awarded the PC3 contracts with the intent of providing veterans with access to inpatient and outpatient specialty care. They awarded the contracts in September 2013 for an estimated value of \$27 billion. However, because of the significant weaknesses that resulted from the lack of oversight and noncompliance with acquisition regulations and VA policies, the actions to develop and award the PC3 contracts did not have the controls necessary to ensure VA's interests were adequately protected. Until VA's acquisition leadership provides oversight and strengthens compliance with regulations and policies, VA acquisition teams will continue to struggle with developing effective contracts that achieve VA's objectives. Specifically, VA needs to provide senior executive leadership and accountability over such high-dollar contracts.

---

<sup>4</sup> *Review of the VHA's Use of Reverse Auction Acquisitions*, Report No. 13-01408-294, September 26, 2014 and *Audit of Support Service Contracts*, Report No. 12-02576-30, November 19, 2014



## Recommendations

1. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) ensure sufficient oversight on all high-dollar value and complex acquisitions to prevent violations of acquisition regulations and VA policies.
2. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) ensure critical planning actions—requirements development, market research, and independent government cost estimates are performed and provided to contracting officers, prior to developing requests for proposals.
3. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) obtain pricing analysis and technical assistance, to ensure quality products and services are procured at fair and reasonable contract prices.
4. We recommended the Principal Executive Director for Acquisition, Logistics, and Construction (and Chief Acquisition Officer) enforce compliance with the VA policy to document all required acquisition decisions in the Electronic Contract Management System.

### ***Management Comments and OIG Response***

The Principal Executive Director for Acquisition, Logistics, and Construction (OALC) concurred with our recommendations but offered technical comments to include suggested changes to three of four of our recommendations. We did not change our recommendations but believe OALC's proposed action plans adequately address our recommendations.

We recommended OALC have sufficient oversight of high-dollar and complex acquisitions. OALC stated it will continue the development of an enterprise governance structure (such as the Acquisition Program Management Framework (APMF)), which will enhance oversight of high-dollar value and complex acquisitions through the entire program development life cycle. OALC's proposed action meets the intent of Recommendation 1.

We also recommended that OALC ensure that critical planning actions such as requirements development are provided to the contracting officer prior to developing the request for proposal. OALC stated that they recognized that more must be done to ensure that higher-quality requirements are received from its customers and then developed to a point where the best solution for the Government is identified. OALC indicated that the APMF when fully implemented would provide the appropriate level of oversight to ensure the contracting officer was provided all the necessary information critical to program planning. OALC's proposed action meets the intent of Recommendation 2.



Recommendation 3 recommended that OALC require pricing and technical assistance to ensure services are procured at fair and reasonable prices. OALC stated that FAR provides contracting officers with a variety of ways to ensure fair and reasonable prices, such as competition or through proposal analysis. They also cited that Integrated Product Teams and its Integrated Oversight Process are in place. OALC requested Recommendation 3 be closed. Although these processes may be in place, we did not find the IPT effective. Thus we did not close this recommendation.

Regarding Recommendation 4, OALC stated that they have existing policy in place and are continuing to monitor eCMS through regular A-123 reviews to ensure compliance with acquisition documentation requirements. OALC advised that they will review data on compliance to determine if additional opportunities for increased compliance are required.

We will follow up on OALC's implementation of its action plan. The Principal Executive Director for Acquisition, Logistics, and Construction's comments can be found in Appendix B.

**Data  
Reliability**

To test the reliability of computer-generated data used during the review, we examined the PC3 contract files to determine if procurement actions were recorded in eCMS. While we identified missing contract documents, our report findings and conclusions were based on information DALC staff provided in addition to what was available in eCMS. The data were sufficiently reliable to achieve the review's objective.

**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 Evaluations*.

## Appendix A Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs
3	Had the pricing documents been thoroughly reviewed, the acquisition team would have noticed the tier 2 and 3 adjustments and declined the new prices.	\$16,800,000	\$0
<b>Total</b>		<b>\$16,800,000</b>	<b>\$0</b>

## Appendix B Management's Comments

### Department of Veterans Affairs

### Memorandum

**Date:** December 18, 2015

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

**Subj:** OIG Draft Report: VA Review of Patient Centered Community Care (PC3) Contracts (15-01396-AR-0074) (VAIQ 7637167)

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

1. The Assistant Inspector General for Audits and Evaluations requested comments on the findings and recommendations in the draft report, "Review of Patient Centered Community Care (PC3) Contracts," to determine whether the Denver Acquisition & Logistics Center (DALC) awards and administers the PC3 services contracts in accordance with the Federal Acquisition Regulation (FAR) and VA policy.
2. The Office of Acquisition, Logistics, and Construction (OALC) has completed its review of the draft report. While OALC concurs with the spirit of the recommendations, we offer the following technical revision to the recommendations that we have begun work to complete. OALC corrective actions will follow each revised recommendation.

**OIG Recommendation 1:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (and acting Chief Acquisition Officer) ensure sufficient oversight on all high-dollar value and complex acquisitions to prevent violations of acquisition regulations and VA policies.

**OALC Recommended Revision to Recommendation 1:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction, as the Chief Acquisition Officer, provide an enterprise governance structure that enables oversight of high-dollar value and high-impact complex acquisitions to improve their probability of success.

**OALC Response:** Concur. OALC will continue the development of an enterprise governance structure (such as the Acquisition Program Management Framework (APMF) that will enhance additional oversight of high-dollar value and complex acquisitions through the entire program development life-cycle. A structure, such as APMF, would centralize governance, oversight, and strategic decision making, allowing senior leaders in the Administrations and Staff Offices to make decisions concerning the health of programs, continued decentralization of day-to-day management and acquisition activities to program managers and contracting officers. The APMF will address this challenge by aligning strategic management processes and synchronizing enterprise priorities, requirements and solutions to foster greater program accountability in support of key decision making. Implementation of this recommendation is ongoing.

**OIG Recommendation 2:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (and acting Chief Acquisition Officer) ensure critical planning actions—requirements development, market research, and independent government cost estimated are performed and provided to contracting officers, prior to developing requests for proposals.

**OALC Recommended Revision to Recommendation 2:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction, (and acting Chief Acquisition Officer) provide enterprise guidance and framework to improve critical planning actions, such as requirements development, market research, and independent government cost estimates, that are performed and provided to contracting officers, prior to developing requests for proposals.

**OALC Response:** Concur. OALC recognizes that more must be done to ensure that higher quality requirements are elicited and then devolved to a point where alternatives are analyzed to determine the best solution for the government and an appropriate cost estimate is made prior to the act of commerce. Specifically, a governance structure, such as APMF, assigns critical planning action roles for business owners, program managers, and contracting officers prior to a program entering its acquisition life-cycle. The APMF will require a strong foundation for an effective, capable, accountable and transparent acquisition process which necessarily includes proper organizational alignment and defined roles and responsibilities. These efforts will deliver the appropriate level of rigor and oversight required to ensure the contracting officer is provided with artifacts that reflect these critical program planning actions. Implementation of this recommendation is ongoing.

**OIG Recommendation 3:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (and acting Chief Acquisition Officer) obtain pricing and technical assistance to ensure quality products and services are procured at fair and reasonable contract prices.

**OALC Recommended Revision to Recommendation 3:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (and acting Chief Acquisition Officer) requires, in accordance with VA and Federal Acquisition regulations, pricing and technical assistance to ensure quality products and services are procured at fair and reasonable contract prices.

**OALC Response:** Concur. Federal Acquisition Regulations (FAR) provides contracting officers a variety of ways to ensure fair and reasonable prices, such as competition or through proposal analysis. VA Procurement Policy Memorandum (PPM) 2013-07, "Use of Integrated Product Teams (IPT) for Major Acquisitions," states the overall goal of the IPT is to ensure adherence to the Federal Acquisition Regulation (FAR) and VA Acquisition Regulation (VAAR) and to deliver a product or service that meets programmatic objectives in terms of cost, quality, and timeliness. IPTs are required for acquisitions with a total value estimated to exceed \$5 million. Additionally, the Integrated Oversight Process requires a Contract Review Board (CRB) for acquisitions with a total value estimated to exceed \$50 million. The CRB reviews the pre-solicitation or pre-award package to minimize vulnerabilities for VA and ensure compliance with established Federal and VA Acquisition regulations and procedures. These processes are in place to increase compliance with acquisition regulations.

**OALC requests closure of this recommendation.**

**Recommendation 4:** We recommended the Principal Executive Director, Office of Acquisition, Logistics, and Construction (as Chief Acquisition Officer) enforce compliance with the VA policy to document all required acquisition decisions in the Electronic Contract Management System (ECMS).

**OALC Response:** Concur. OALC established policy requiring contracting activities to enter all appropriate contract documents into ECMS in procurement policy memorandum, Mandatory Usage of VA's Electronic Contract Management System, dated June 15, 2012 (see Attachment 1). OALC reinforced this requirement by issuing an Acquisition Flash 15-06, on November 12, 2014, reminding contracting staff of this requirement (see Attachment 2). Additionally, eCMS files are reviewed as a standard part of our A-123 reviews where the team determines if appropriate documentation is present and the quality of that documentation. Over the past few years the A-123 reviews have seen a significant increase in compliance in this area. OALC will review data on compliance to determine if additional opportunities for increased compliance is required.

With regard to the specific contract reviewed in this audit, all eCMS files have been re-populated with all documentation required by regulation and policy (see screenshots in Attachment 3). Implementation of this recommendation is ongoing.

3. Should you have any questions regarding this submission, please contact Ms. Melanie Griffin or Annette Powe at (202) 632-4606 or [vaalccorrespondence@va.gov](mailto:vaalccorrespondence@va.gov).

*(Original signed by:)*

GREGORY L. GIDDENS

Attachments\*

*\*OIG Note: Due to the number and length of the attachments, they were not included in this report. They are available through the VA OIG Information Officer.*

## Appendix C **OIG Contact and Staff Acknowledgments**

---

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
---------	---

---

Acknowledgments	Judith Sterne, Director Janet Mah, Director Christopher Bowers Roland Baltimore Kimberly Choplin Gregory Gladhill Benjamin Howe Sunny Lei Herlin Guerra-Sagastume Thomas Pasquini Angela Sneed Jamie Wright
-----------------	--

## **Appendix D Report Distribution**

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Veterans Benefits Administration  
National Cemetery Administration  
Assistant Secretaries  
Office of Acquisition, Logistics, and Construction  
Office of General Counsel

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Construction,  
Veterans Affairs, and Related Agencies  
House Committee on Oversight and Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction,  
Veterans Affairs, and Related Agencies  
Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget

**This report is available on our Web site at [www.va.gov/oig](http://www.va.gov/oig).**