

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Veterans Health Administration

*Review of
the Implementation of
the Veterans Choice
Program*

January 30, 2017
15-04673-333

ACRONYMS

CBO	Chief Business Office
FY	Fiscal Year
NVC	Non-VA Care
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
TPA	Third-Party Administrator
VA	Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VCL	Veterans Choice List
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Why We Did This Review

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted this review at the request of U.S. Senator Johnny Isakson, Chairman of the Senate Committee on Veterans' Affairs, who expressed concerns about the implementation of the Veterans Choice Program (Choice) and, more specifically, about the barriers facing veterans trying to access it. Thus, our review focused on determining whether veterans were experiencing barriers accessing Choice during its first year of implementation, taking into account that this program, as noted by the Under Secretary for Health in his comments attached to this report, has evolved since that time. We will continue our oversight of Choice in FY 2017 and our assessment of the efficacy of VA's actions to improve the program's overall effectiveness; as well, we will seek to identify significant program risks delivering these vital health care services.

Background

Choice was preceded by the Patient-Centered Community Care (PC3) Program. PC3 is a Veterans Health Administration (VHA) nationwide program that utilizes service contracts to provide care for eligible veterans when the local VHA medical facilities lack available specialists, have long wait times, or are geographically inaccessible. In September 2013, VA awarded the initial PC3 contracts to third-party administrators (TPAs)—Health Net Federal Services, LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) as a supplement to the Non-VA Care (NVC) Program. PC3 began health care delivery in January 2014. In October 2014, VA amended the PC3 contracts, adding \$300 million to their value, with Health Net and TriWest, to include the administration of Choice.

VHA policy states that when a veteran attempts to schedule an appointment at a VHA medical facility and cannot be seen within 30 days, the veteran is placed on the Veterans Choice List (VCL). Once added to the VCL, the veteran has the choice to opt into the program and pursue care from a TPA's network provider for that appointment. Veterans may be added to the VCL multiple times if they have more than one appointment with a wait time exceeding 30 days.

Veterans are also eligible for Choice if they reside more than 40 miles from a VHA medical facility; must travel by air, boat, or ferry to reach a VHA facility; or face an unusual or excessive burden in accessing a VHA facility. This report focused on the utilization of Choice by veterans who were eligible under the 30 days' wait criteria—the VCL reflects the number of appointments needed to serve this group. We were unable to ascertain the demand for medical services for the veterans eligible under the 40-mile criteria. Choice covers only pre-authorized medical care and does not pay for veterans' emergent or urgent medical needs. Veterans may be

eligible for emergent or urgent care through the NVC Program.¹

What We Did

We conducted our review from August 2015 through May 2016. We reviewed contractor-provided monthly reports issued from November 1, 2014 through September 30, 2015 to identify average wait times for multiple stages of the Choice process, including the authorization of care, scheduling, and the delivery of health care to veterans. To determine authorization wait times, we used the same reports to compare dates for times when the veteran opted into the program, when the authorization was created, when the appointment was scheduled or returned, and when the appointment occurred. To assess the implementation of Choice at the local VHA medical facility level, we visited the Atlanta VA Health Care System, and seven other randomly selected VHA medical facilities. We chose the Atlanta VA Health Care System because of the issues raised by Senator Isakson about that facility in his letter to the VA OIG. For the other locations, we used the number of veterans waiting for more than 30 days for VA appointments on the VCL as of June 1, 2015 and developed a stratified sampling approach. The three strata were based on the number of veterans waiting over 30 days for VA appointments on the VCL² at each individual facility.³

From the three strata, we randomly selected these VHA medical facilities:

- VA Greater Los Angeles Healthcare System, CA
- VA Eastern Colorado Health Care System, CO
- North Florida/South Georgia Veterans Health System, FL
- John J. Pershing VA Medical Center, MO
- Kansas City VA Medical Center, MO
- South Texas Veterans Health Care System, TX
- VA Salt Lake City Health Care System, UT

What We Found

We determined that veterans faced several barriers accessing medical care through Choice during its first 11 months of implementation from November 1, 2014 through September 30, 2015. The observations expressed in this report reflect the barriers faced by veterans during this period after VA struggled to meet a 90-day implementation timeline mandated by the Veterans Access, Choice, and Accountability Act of 2014 (VACAA). Primary barriers included cumbersome authorization and scheduling procedures, and inadequate provider networks. Before receiving an

¹ Emergency care for veterans may be authorized if veterans meet the criteria found in Title 38 USC §1703 or 38 USC §1725 or 38 USC §1728.

² Previous OIG reports found problems with the accuracy of VHA wait-time data. For the purpose of this report, we did not review wait-time data to determine if more veterans were waiting over 30 days for treatment and should have been added to the VCL because of scheduling errors.

³ Appendix B provides more detail on the sampling methodology employed.

appointment with a network provider, veterans had to first navigate through Choice's authorizing and processing procedures. These procedures included eligibility reviews, decisions to opt into the program, and transfer of medical documentation by VHA to Health Net and TriWest. This process averaged 32 days—two days longer than VHA's standard for completing an appointment within 30 days. After being scheduled with a Choice provider by the TPA, on average the veteran waited about 13 days to receive care. In total, veterans waited approximately 45 days on average from the time they opted into pursue medical treatment to the time they received care through Choice. We did not review individual cases to determine if patient harm occurred as a result of waiting for treatment in excess of the 30-day standard.

Choice's inadequate network of providers created barriers for veterans trying to access care outside of VHA medical facilities. VHA recognized that networks were inadequate shortly after the program was implemented in November 2014 and sent several noncompliance letters to the concerned TPAs to try to correct the problem. To facilitate the contractors' development of adequate networks, the Acting Deputy Under Secretary for Health for Operations and Management issued a memo in June 2015 instructing Veterans Integrated Service Network (VISN) directors to help TPAs develop their provider networks. From November 1, 2014 through September 30, 2015, VHA added 1.2 million appointments to the VCL for veterans waiting over 30 days for care at VHA medical facilities. During the same period, more than 283,500 Choice authorizations were created for veterans who opted in because VHA medical facilities could not provide them treatment within 30 days. Of these 283,500 authorizations:

- Approximately 149,400 (53 percent) were for veterans who were able to receive care; on average, these veterans waited 45 days for treatment from the date they chose to opt into Choice.
- Approximately 36,000 (13 percent) were returned to VHA without the veterans receiving care. On average, authorizations were returned to VHA approximately 48 days after the veteran decided to opt into Choice. About half of the returned authorizations were sent back because Choice was unable to schedule the appointment with an appropriate provider or the appointment offered to the veteran was declined. The other half of returned authorizations were sent back because they were missing VA data, veterans requested specific providers outside the network, VHA requested that the authorizations be returned, or the veterans did not show up for their appointments.
- Approximately 98,200 (35 percent⁴) were still waiting for TPAs to schedule appointments as of September 30, 2015. On average, for authorizations that had not been scheduled, veterans were waiting 72 days to receive an appointment from the TPA.

Another potential barrier is the possibility that veterans were deterred from seeking care through the Program because of concern about being personally liable for treatment costs after providers began billing veterans directly for care that had not been paid for by the TPAs. VHA lacked strong oversight of TPA payments to network providers. If these payments are delayed, there are

⁴ Does not add to 100 percent due to rounding

no safeguards to prevent the veteran from being billed for any unpaid medical claims and experiencing adverse credit reporting.⁵

Pursuant to the request made by Senator Isakson, we randomly selected 240 patient medical records from the eight VHA medical facilities to test whether staff were encouraging veterans to wait for a VHA appointment or to use Choice. We reviewed VA clinical notes and documentation for each veteran record. We also reviewed notes and medical records in the TPAs' portals. Specifically, we looked for scheduler comments, script deviations, and any unjustified delays in scheduling that would suggest VA medical staff were influencing veterans to wait for VHA appointments.

In addition, we surveyed 129 VA staff from the eight VHA medical centers we visited in August and September 2015 to determine if VHA medical facility staff were discouraging veterans to participate in Choice. Medical facility leadership, clinicians, schedulers, and Choice Champions interviewed by the OIG during our site visits participated in the survey. The majority of those surveyed (77 percent) either agreed or strongly agreed that VHA was encouraging veterans to use Choice. Only four percent responded that VHA was discouraging veterans from using Choice and 19 percent responded that VHA was neither encouraging nor discouraging the use of Choice.

We also reviewed the training of scheduling staff and interviewed schedulers at the eight facilities to ensure they used standardized scripts provided by the Chief Business Office (CBO) to communicate to veterans Choice eligibility requirements and scheduling procedures. We determined that seven of the eight facilities we visited provided the appropriate training to scheduling staff. Based on this sample, we did not find that VHA medical staff were influencing veterans to wait for their scheduled VA appointments or discouraging veterans from using Choice.

Why This Occurred

After VACAA was enacted in August 2014, VA had only 90 days to fully implement Choice. This posed many challenges for VA. We interviewed three VHA CBO officials and two contracting officers responsible for the PC3/Choice contracts; all stated that this aggressive timeline was not achievable. Thus, to meet VACAA's 90-day implementation timeline, VA and VHA officials decided that the best course of action was to outsource the program's administration to a TPA. VHA did not give TPAs detailed information on the types of health care services their networks needed to provide in specific geographic locations. VA contracted a

⁵ In their February 2016 testimony before the House Committee on Veterans' Affairs, Subcommittee on Health, VHA officials acknowledged that this was an issue many veterans had reported. VHA established the Community Care Contact Center, a program to help veterans who were being billed for medical care by Choice network providers. According to VHA, from its inception on January 29 through April 18, 2016, the call center received 4,250 phone calls from veterans requesting help with their credit. Typically, to mitigate the effect on a veteran's credit report, the Community Care Contact Center reaches out to the community provider and requests that the veteran's account be put on hold (rather than sending the veteran's account to a collection agency). As of April 2016, VHA had resolved 789 of 1,329 adverse credit-reporting issues.

private-sector entity to conduct an independent assessment of the hospital care, medical services, and other health care performed in VHA's medical facilities.⁶ One of their key findings was that VA needed a patient-centered demand model that forecasts the resources needed by geographic location, to improve access, and make informed resourcing decisions.

Under the original PC3 contracts, VHA reimbursed the TPAs for medical and surgical care at rates typically three to five percent below Medicare reimbursement rates. When the contracts were modified to include Choice, language from VACAA was incorporated, namely, that all Choice care, other than highly rural care, would be reimbursed at rates not to exceed Medicare. Under the TPA contracts, TPAs were allowed to refer Choice patients to PC3 providers. PC3 providers would be reimbursed at rates determined by their network-provider agreement with the TPAs, which allowed discounts from Medicare rates.

As of October 20, 2016, Health Net Choice Provider agreements stated that if a provider was or became a participating provider under VA's PC3 Program, the terms of the Health Net Federal Services PC3 Agreement, including the reimbursement rates, would take precedent over the Choice Agreement. The Health Net website also described PC3 providers as their Preferred Provider Network for all current and future VA programs and is considered the first option in their internal referral and authorization system. VA officials noted that the various reimbursement schedules were confusing to community providers about what rate they would be paid when providing care to veterans.⁷ VA officials concluded that this situation may be restricting the expansion of provider networks serving veterans.⁸ At the time of our review, VHA was planning to replace the existing PC3/Choice contracts. For this new contract effort to be successful, VHA will need to ensure our recommended changes are addressed in a timely manner.

What Resulted

VHA identified on the VCL approximately 1.2 million instances in which veterans could not receive appointments at VHA medical facilities within 30 days from November 1, 2014 through September 30, 2015. During the same period, about 283,500 veterans who were waiting over 30 days for medical care at a VHA facility opted into Choice, according to the TPAs' monthly reports, and 149,000 of these veterans who opted in received an appointment with a Choice provider.

We calculated a 13 percent rate of Choice utilization based on the number of Choice appointments that were provided (149,000) compared to the number of veteran appointments that were eligible to receive care (1.2 million) through Choice (as shown on the VCL). We also determined a three percent utilization rate among eligible veterans for services such as Choice Primary Care and Mental Health Services. VACAA specifically provided an additional \$5

⁶ MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, September 1, 2015.

⁷ *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, Department of Veterans Affairs, pg. 52.

⁸ *Ibid*, pg. 12.

billion in funding to the \$10 billion authorized for Choice, to address VHA staffing shortages for these services.

We were unable to determine why the other 87 percent did not access Choice: there could be a variety of reasons. As the Under Secretary for Health noted in his response to this report, the Veterans of Foreign Wars conducted a survey in March 2015 that found that 47 percent of the survey participants reported that they chose to retain care in VA rather than through Choice. In his response found in Appendix C, the Under Secretary for Health expressed reservations with this methodology, stating that VHA calculated utilization by capturing only the veterans who have opted into the program. For its part, the OIG chose not to limit its scope to only veterans who opted in, so it could address barriers veterans faced when trying to access Choice—including barriers that prompted them to not participate in the program. When calculating utilization based on only those veterans who opted in and received an authorization for care, 53 percent of the veterans received treatment, 13 percent had their authorizations returned to VHA, and 35 percent had yet to receive an appointment as of September 30, 2015.⁹

In August 2014, Congress appropriated \$10 billion for Choice: of that \$10 billion, \$300 million was set aside to start and administer the program and \$9.7 billion was to provide medical care. From November 2014 through September 2015, VHA spent \$164.9 million in implementation and administrative fees or 55 percent of the \$300 million. VHA spent \$155.5 million of the \$164.9 million in Choice administrative funds on program startup costs, i.e., to issue Choice Cards, create provider networks, and establish Choice call centers. The remaining \$9.5 million¹⁰ of administrative funds was spent on the day-to-day administration of Choice. For the same period, VHA obligated \$412.9 million for medical care provided during the first eleven months of the program, of which approximately \$16 million was expended during that period.

By the end of May 2016, however, Choice spending for medical care had improved significantly with \$206.3 million (40 percent) of resources used for implementing and administering the program and \$306.4 million (60 percent) for direct medical care. In addition, VHA had spent \$1.6 billion of the Choice funding outside of Choice on emergency care and Hepatitis C treatment for veterans—which was allowed by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

What We Recommended

We recommended the Under Secretary for Health streamline procedures for accessing care, develop accurate forecasts of demand for care in the community, reduce providers' administrative burdens, ensure veterans are not liable for authorized care, and ensure provider payments are made in a timely manner.

⁹ Figures in this sentence are rounded to the nearest whole percentage.

¹⁰ Difference due to rounding

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendation 1 by November 2016, Recommendation 2 by August 2016, and Recommendation 3 in October 2016. The Under Secretary for Health in his response in Appendix C stated that Recommendations 4, 5, and 6 had been completed. The Under Secretary's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. As of November 2016, VHA had not provided us with the evidence necessary to close Recommendations 2, 4, 5, and 6. Once we receive such evidence, we will examine it carefully to determine whether VHA's actions are sufficient to close the recommendations.

The Under Secretary added that VHA is committed to improving community care for veterans, community providers, and VHA employees. VHA wants to deliver a program that is easy to understand, simple to administer, and meets the needs of veterans, community providers, and VHA staff. The Under Secretary stated that VHA is focusing on a plan targeting five key areas that influence a veteran's health care journey through community care: eligibility, referral and authorization, care coordination, community care network, and provider payments. The Under Secretary also stated that recent accomplishments have helped improve the health care experience for veterans, have strengthened relationships with community providers, simplified processes for VHA staff, and increased utilization of community care.



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INTRODUCTION

Purpose for the Review

In July 2015, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received a letter from U.S. Senator Johnny Isakson, the Chairman of the Senate Committee on Veterans' Affairs expressing concerns with the implementation of the Veterans Choice Program (Choice). Our review objective was to determine whether veterans experienced barriers accessing Choice. We plan to continue our oversight of Choice in FY 2017 and to assess the effectiveness of VA's actions to improve the overall effectiveness of the program and to fully identify significant program risks delivering these vital health care services.

Background

The Veterans Access, Choice, and Accountability Act of 2014 (VACAA) was enacted on August 7, 2014 to improve veterans' access to Veterans Health Administration's (VHA) medical services by appropriating \$10 billion for veterans to receive care from non-VA providers. In November 2014, VA implemented the program and began authorizing patients to use the program in accordance with the 90-day timeline established by VACAA. On July 31, 2015, the VA Budget and Choice Improvement Act was enacted, which, among other things, expanded eligibility requirements and required VA to develop a plan to consolidate all non-VA provider programs under Choice.

According to VHA policy, when a veteran attempts to schedule an appointment at a VHA medical facility and cannot be seen within 30 days, the veteran is placed on the Veterans Choice List (VCL). Once added to the VCL, the veteran then has the choice to opt into the program and pursue care from a third-party administrator's (TPA) network provider for that appointment. Veterans may be added to the VCL multiple times if they have more than one appointment with a wait time over 30 days.

Veterans are also eligible for Choice if they reside more than 40 miles from a VHA medical facility; must travel by air, boat, or ferry to reach a VHA facility; or face an unusual or excessive burden in accessing a VHA facility.

This report focused on the utilization of Choice for veterans who were eligible for the program under the 30 days wait criteria because the number of appointments needed for this group was known. We were not able to ascertain the demand for medical services for the veterans eligible under the 40-mile criteria. Choice covers only pre-authorized medical care and does not pay for veteran's emergent or urgent medical needs. Veterans may be eligible for emergent or urgent care through the Non-VA Care (NVC) Program.

**Program
Administration**

The Assistant Deputy Under Secretary for Health for Community Care is responsible for the strategic and long-term planning for the program. The VHA Chief Business Office (CBO) provides oversight of day-to-day operations of Choice. The CBO established contracts with two TPAs—Health Net Federal Services LLC (Health Net) and TriWest Healthcare Alliance Corporation (TriWest)—to establish provider networks, schedule appointments, collect medical documentation, and make payments for medical care. In October 2014, VA amended the Patient-Centered Community Care (PC3) contracts with Health Net and TriWest to include administration of Choice. The contract amendments were valued at \$300 million. PC3 is a VHA nationwide program that uses service contracts to provide health care for eligible veterans when the local VHA medical facilities lack available specialists, have long wait times, or are geographically inaccessible.

**Program
Expenditures**

From October 30, 2014 through May 31, 2016, VHA paid about \$512.7 million to the two TPAs, of which \$306.4 million (60 percent) was spent for medical care and the remaining \$206.3 million (40 percent) was for implementation and administrative fees. It should be recognized that since Choice began its implementation in November 2014, administrative costs as a percentage of expenditures likely would be higher at the outset. The Under Secretary of Health noted in his response to this report that, as of May 2016, administrative costs represented less than 10 percent of total obligations.

RESULTS AND RECOMMENDATIONS

Finding **Veterans Face Significant Barriers Accessing the Veterans Choice Program**

VA was required to implement Choice within 90 days and this created many challenges for VA. Veterans struggled to access medical care through Choice because of significant barriers including a cumbersome process for scheduling care, inadequate provider networks, and veterans potentially being liable for their care. These barriers occurred primarily because administrative burdens placed on network providers and low reimbursement rates discouraged their participation. From November 1, 2014 through September 30, 2015, utilization of the program for veterans who were waiting more than 30 days for care at VHA medical facilities was 13 percent of the appointments eligible to receive care through Choice. Of those veterans who opted into Choice and received authorization for care, 53 percent of the veterans received care, 13 percent had their authorizations returned to VHA, and 35 percent had yet to receive an appointment as of September 30, 2015. Veterans waited an average of 45 days to see Choice providers to receive care.

VA's Effort To Educate Veterans About Choice

Choice was implemented with the goal of increasing veterans' access to medical care. VHA took several steps to ensure veterans were aware of Choice. VHA mailed out information about Choice cards, and issued press releases and blog posts when there were changes to the program. After performing an assessment of VA's social media accounts, we determined that VHA used social media, such as Facebook, Twitter, and Google Plus Hangout, to address veterans' questions about Choice. In addition, we observed outreach communications at the VHA medical facilities we visited in August and September 2015, such as advertisements on directory monitors and on the back of cafeteria receipts.

The Chairman of the Senate Committee on Veterans' Affairs asked whether staff at VHA medical facilities were encouraging veterans to wait for a VHA appointment rather than using Choice. To answer this question, we randomly selected 240 patient medical records from the eight sampled VHA medical facilities. For each veteran record, we reviewed VA clinical notes and documentation. We also reviewed notes and medical records in the TPAs' portals. Specifically, we looked for scheduler comments, script deviations, and any unjustified delays in scheduling that would imply VA medical staff were influencing veterans to wait for VA appointments.

In addition, we surveyed 129 VA staff from the eight VA medical centers we visited in August and September 2015 regarding veterans being encouraged to participate in Choice. Medical facility leadership, clinicians, schedulers, and Choice Champions interviewed by the OIG during the course of this

review participated in the survey. The majority of those surveyed (77 percent) either agreed or strongly agreed that VA was encouraging veterans to use Choice and 19 percent responded that VHA was neither encouraging nor discouraging the use of Choice. Only four percent believed VA was discouraging veterans from using Choice.

We also reviewed the training of schedulers at the eight facilities to ensure they used standardized scripts provided by the CBO to communicate Choice eligibility requirements and scheduling procedures to veterans. We determined seven of the eight facilities we visited had provided the appropriate training to scheduling staff. Based on medical and training record reviews and interviews with medical staff members, we did not conclude that VHA medical staff were influencing veterans to wait for their scheduled VA appointments or discouraging veterans from using Choice.

**Cumbersome
Choice
Process
Created
Barriers
to Access**

However, the procedures used to authorize and schedule appointments under Choice from November 1, 2014 through September 30, 2015 were cumbersome and required veterans to schedule their treatment without assistance from their VHA provider or VHA facility staff. These procedures placed a greater burden on veterans than seeking treatment in VHA facilities, and according to VHA clinicians, required them to manage their own care through a TPA. Some VHA clinicians expressed concerns this may have affected the quality of care veterans received because the TPAs scheduled appointments with no input from VHA clinicians. They also questioned the ability of TPA Call Center staff to make appropriate referrals. The following are examples of inappropriate referrals shared by veterans and VHA medical staff during our audit site visits.

Example 1

A veteran living in Idaho, who was more than 40 miles from the closest VA medical facility, needed treatment for pain caused by a herniated disk in his back. He was scheduled for a Primary Care appointment by Health Net with a physician in New York.

Example 2

A veteran served by the South Texas Veteran Healthcare System needed surgery for wrist pain, but TriWest scheduled an appointment with a specialist who was unable to perform this surgery.

Example 3

A veteran served by Gainesville VA Medical Center in Florida needed to see an Ear, Nose, and Throat specialist, but Health Net scheduled an appointment with a specialist in California.

Prior to implementation of Choice, the primary means for veterans to obtain care outside of the VHA was the NVC Program. The NVC Program did not employ TPAs as used by Choice. VA recognized the importance of basic care coordination of appointments and scheduling for veterans, enabling

them to know who to see, when to go, and why. VA also acknowledges most veterans will use this level of care coordination.¹¹

*Choice
Process
Is More
Cumbersome
Than NVC*

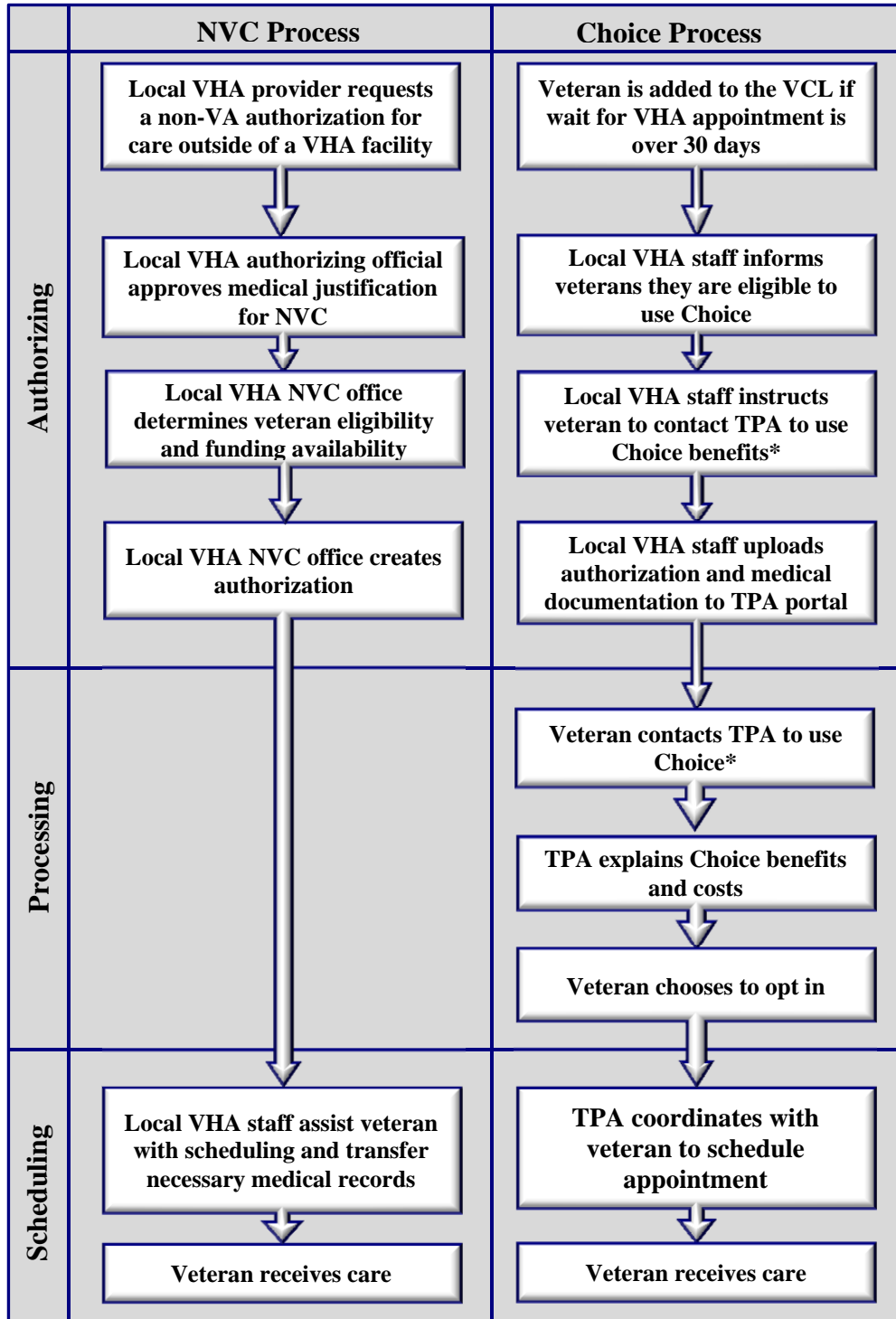
The three major components of obtaining an appointment (authorizing, processing, and scheduling) were more cumbersome under Choice than previously required under the NVC Program. The Choice authorization procedures required extensive coordination between VHA staff to create authorizations and transfer medical records through the TPA's portal prior to the veteran contacting the TPA to schedule an appointment with a network provider. Because of this cumbersome process, it took veterans an average of 32 days for their authorizations for care to be authorized and processed. Appendix A describes each step of the Choice process in more detail.

Some VHA clinicians expressed concerns about patients being required to coordinate their own care with TPAs. Under the NVC Program, VHA physicians and clinical staff would routinely assist patients with referrals for treatment and schedule appointments with non-VA providers if the patient needed additional assistance. In contrast, the Choice process requires that veterans manage this task independent of their VHA physicians and medical staff. VHA clinicians we spoke with were concerned that mental health or elderly patients would struggle to navigate a system in which they were responsible for managing their own care.

¹¹ *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, Department of Veterans Affairs, pg. 22.

Figure 1 compares the key steps required to obtain a veteran's appointment under the NVC and Choice Programs.

Figure 1. NVC Versus Choice Processes



Source: *OIG summary of Choice Business Process Flow dated December 12, 2014*

* Choice standard operating procedures as of November 2015 require the TPA to contact the veteran to determine if they desire to use Choice medical treatment

**Inadequate
Networks
Created
Barriers
to Access**

Choice's inadequate network of providers created barriers for veterans who sought to access care outside of VHA medical facilities. According to data provided by TPAs, from November 1, 2014 through September 30, 2015, over 283,500 Choice authorizations were created requesting an appointment for veterans who were waiting over 30 days for care at VHA medical facilities.

- Approximately 149,400 (53 percent) were for veterans who were able to receive care; on average, these veterans waited 45 days for treatment from the date they chose to opt into Choice.
- Approximately 36,000 (13 percent) were returned to VHA without the veterans receiving care. On average, authorizations were returned to VHA approximately 48 days after the veteran decided to pursue an appointment through Choice. Approximately 17,900 or 50 percent of 36,000 returned authorizations were sent back because Choice was unable to schedule the appointment with an appropriate provider or the appointment offered to the veteran was declined. The remaining 18,100 or 50 percent of the 36,000 returned authorizations were sent back because they were missing VA data, veterans requested specific providers outside the network, VHA requested the authorizations be returned, or the veteran did not show up to the appointment.
- Approximately 98,200 (35 percent) were still waiting for TPAs to schedule appointments as of September 30, 2015. On average, for authorizations that had not been scheduled, veterans were waiting 72 days to receive an appointment from a TPA.

We found additional evidence of network inadequacy in the TPAs' contract files. For example, since the program began in November 2014, VA contracting officers issued three noncompliance letters that identified issues with network adequacy and deducted approximately \$2.6 million in administrative fee payments for TPA's inability to develop adequate networks.

TPAs made efforts to address these challenges by working with local VHA medical facilities to better serve each facility's needs. One TPA expressed frustration with VHA's inability to define its demand for specialty care in its response to one noncompliance letter.

VHA recognized networks were inadequate shortly after the program was implemented in November 2014. To facilitate the contractors' development of adequate networks, the Acting Deputy Under Secretary for Health for Operations and Management published a memo in June 2015 instructing Veterans Integrated Service Network (VISN) directors to assist TPAs in developing their provider networks. The memo stated that the VHA's CBO for Purchased Care would issue letters to the top 100 traditional NVC

community providers who were not already a PC3 or Choice network provider asking them to join the network.

One medical facility chief of staff provided us with an email and documents from the VISN director instructing each medical facility to identify a key executive who would be responsible for follow-up with phone calls to each of the facility's top 100 NVC providers who received recruitment letters from VA requesting they participate in Choice. At another VA medical facility, the director stated she was hiring a program analyst to manage this recruiting effort.

Despite efforts on the part of the TPAs and VHA to enhance provider networks, VA has acknowledged that it does not have ongoing visibility into all provider locations, or an understanding of supply and demand imbalances.¹² This has resulted in veterans on the VCL still struggling to obtain medical care through Choice.

**Fear of
Financial
Liability
Created
Barriers
to Access**

An additional barrier is the risk that veterans are financially liable for their care. Under Choice, the network providers are responsible for collecting the veterans' insurance information, and if the treatment was for a nonservice-connected condition, the network providers were responsible for collecting insurance copayments and billing the veterans' insurance companies for their treatment. During our interviews with VHA medical facility staff, we were told of some instances in which veterans were billed for some or all of their care.

Under the PC3/Choice contracts there were no performance measures that gave VA oversight of the TPAs' payments to their network providers. Furthermore, VA had no authority under the contracts to ensure TPAs paid their network providers in a timely manner. This is unfortunate since payment delays may have resulted in network providers seeking reimbursement from the veteran directly or discontinuing their participation in Choice.

In testimony on February 11, 2016, before the House Committee on Veterans' Affairs, Subcommittee on Health, VHA officials acknowledged this was an issue many veterans reported, and they stated they had begun writing letters on behalf of veterans whose credit reports were affected by collection agencies.

VHA established the Community Care Contact Center, a program to assist veterans who were being billed for medical care by Choice network providers. According to VHA, from its inception on January 29, 2016 through April 18, 2016, the Community Care Contact

¹² *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, Department of Veterans Affairs, pg. 63.

Center received 4,250 phone calls from veterans requesting help with their credit. To mitigate the effect on a veteran's credit report, the Community Care Contact Center reaches out to the community provider and requests the veteran's account be put on hold (rather than sending the veteran's account to a collection agency) while the issues are researched. According to VHA, as of April 21, 2016, the Community Care Contact Center had 1,329 veteran accounts placed on hold, and had resolved 789 of the adverse credit reporting issues.

***Mandated
90-Day
Implementation
Caused
Barriers***

One of the reasons veterans faced barriers accessing treatment was due to the expedited implementation of Choice. After VACAA was enacted in August 2014, VA had only 90 days to fully implement Choice.¹³ We interviewed officials at VHA's CBO, and none believed this aggressive timeline was reasonable. However, to meet VACAA's 90-day timeline, VA and VHA officials decided the best course of action was to outsource the program's administration to a TPA.

***No Contractors
Willing
To Implement
Program
in 90 Days***

Around September 2014, VA held an industry day to showcase Choice to potential TPA contractors. During the industry day, several contractors expressed interest in administering Choice; however, all were dissuaded by the requirement to implement provider networks within 90 days believing the short timeline for creating a provider network to meet VHA's needs was not achievable, according the contracting officer overseeing the procurement effort.

After realizing there were no potential vendors interested in bidding to administer the program, VHA turned to the administrators of the PC3 Program (Health Net and TriWest), who had provider networks in place nationwide even though there were known issues with the adequacy of these networks. Among the network inadequacies cited in the noncompliance letters were mammography, gastroenterology, neurology, physical therapy, and radiology. In February 2014, nine months prior to implementation of Choice, VA issued a noncompliance letter to TriWest identifying issues with network inadequacy under its existing PC3 contract. In September 2014, two months before implementing Choice, VA issued a corrective action letter to Health Net also addressing PC3 network adequacy problems.

***VA Amends
PC3 Contracts
To Administer
Choice***

On October 30, 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of Choice. The contract amendments were valued at \$300 million, of which approximately \$155.5 million was provided to create a network of Choice providers. This was a significant increase from the approximately \$22 million provided to Health Net and TriWest to create a network of providers under the original PC3 contracts. The

¹³ Public Law 113-146, August 7, 2014, Section 101, paragraph (f)(1).

amended PC3 contracts allowed veterans who are authorized to receive care under Choice to see a PC3 or Choice network provider.

The contract performance measures of network adequacy were essentially unchanged by the contract amendments to implement the Choice requirements. Our *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy*¹⁴ identified weaknesses in the TPAs' provider networks. These weaknesses occurred because VHA did not provide PC3 contractors specific information on what type of health care services their networks needed to provide in specific geographic locations. VHA also lacked a clear implementation strategy and struggled to coordinate the development of provider networks that met local veteran needs. Problems that existed under the PC3 Program were not resolved before allowing Health Net and TriWest to administer Choice.

*VHA Struggles
To Forecast
Demand for
Choice*

VACAA required VA to contract with a private sector entity to conduct an independent assessment of the hospital care, medical services, and other health care performed in VHA's medical facilities.¹⁵ The MITRE Corporation created a Blue Ribbon Panel composed of health experts to perform this task.¹⁶ The panel's *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* was released in September 2015. One of the report's key findings was that VA needs a patient-centered demand model that forecasts resources needed by geographic location to improve access and make informed resourcing decisions. This tool needs to be able to forecast demand at the local facility level and fine-tune its estimates of required resources.

VA's contracts with the TPAs did not identify VHA's demand for specialty care and the geographic locations where the demand is concentrated. Instead, the contracts' performance measures required that TPAs focus on commuting distances for veterans to obtain care. These measures did little to ensure TPAs had the necessary specialists available to meet veterans' demand for services because they did not take into account veterans who were unable to obtain care through Choice.

We previously reported that VHA's CBO did not provide PC3 contracting officers with sufficient data to develop adequate network access performance measures.¹⁷ MITRE's report supports our previous finding that network adequacy standards should have been based on the forecasted demand for specialty care services by VHA medical facilities' geographic locations.

¹⁴ Report No. 15-00718-507, September 29, 2015.

¹⁵ Public Law 113-146, August 7, 2014, Section 201, paragraph (a)(1).

¹⁶ The MITRE Corporation is a not-for-profit organization that operates research and development centers sponsored by the Federal Government.

¹⁷ Issue was previously reported in the *Review of Patient-Centered Community Care (PC3) Provider Network Adequacy* (Report No. 15-00718-507, September 29, 2015).

VHA has provided an action plan to address our recommendation on this issue from our previous report.

Administrative Burdens and Reimbursement Rates Caused Barriers

Network providers participating in Choice faced additional administrative burdens compared with those who participated in the NVC Program. Requiring more effort on behalf of network providers for the same or lower compensation they had received through the NVC Program was a barrier to their participation in Choice. VA recognized that they need to match payment rates and reduce variance in the rates paid to community providers.¹⁸ VA noted that the various reimbursement schedules were confusing to community providers about what rate they will be paid when seeing veterans.¹⁹ VA concluded that this situation may be restricting the expansion of provider networks serving veterans.²⁰ Table 1 shows the additional effort required by providers who participated in Choice versus the NVC Program.

Table 1. Comparison of NVC and Choice Administrative Burdens and Reimbursement Rates

Requirement	NVC	Choice
Billing Veterans' Other Health Insurance for Nonservice-Connected Treatment	VHA	Network Provider
Collection of Other Health Insurance Copayments From Veteran	N/A	Network Provider
Documentation Required From Network Provider for Reimbursement	Claim for Services*	Claim for Services, Clinical Documentation,** Explanation of Benefits
Reimbursement Rates	Medicare	Medicare and Below

Source: Analysis of network provider agreements and NVC policies

*Authorized inpatient care requires submission of the discharge summary.

**VA discontinued this requirement on March 1, 2016.

¹⁸ *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, October 30, 2015, Department of Veterans Affairs, pg. 51.

¹⁹ *Ibid*, pg. 52.

²⁰ *Ibid*, pg. 12.

In contrast, Choice network providers faced additional administrative burdens that NVC providers did not. First, Choice providers were required to obtain and bill veterans' other health insurance for all nonservice-connected treatment they provided and to collect any related copayments. In addition to claims for their services, Choice network providers had to provide clinical documentation and an Explanation of Benefits showing other health insurance was billed for nonservice-connected treatment. This documentation had to be submitted timely to the TPA or reimbursement might be denied according to the terms of provider agreements between the TPA and network provider. On March 1, 2016, VA amended the contracts with the TPAs to allow payments to the network providers prior to receiving clinical documentation.

Some Network Providers May Be Reimbursed at Rates Below Medicare

Providers may have also received reimbursement that was below Medicare rates. VACAA prevents VHA from paying above Medicare rates unless the veteran resides in a highly rural area. However, the law and the Choice contracts did not prevent the TPAs from paying below Medicare rates, which discourages providers from participating. Under the original PC3 contracts, VHA reimbursed TPAs for medical and surgical care at rates typically 3 to 5 percent below Medicare reimbursement rates. TPAs were allowed to take additional discounts when negotiating agreements with their PC3 providers.

When the PC3 contracts were modified to include Choice, they included language from VACAA that all Choice network providers would be reimbursed at Medicare rates except those in highly rural areas who could be paid above Medicare rates. However, because the contracts allowed PC3 network providers to serve veterans in Choice, the TPAs were still allowed reimbursement below Medicare rates. As of October 20, 2016, Health Net Choice Provider agreements stated if a provider is or becomes a participating provider under VA's PC3 Program, the terms of the Health Net Federal Services PC3 Agreement, including the reimbursement rates, take precedent over the Choice Agreement. The Health Net website also describes PC3 providers as their Preferred Provider Network for all current and future VA programs and is considered the first option in their internal referral and authorization system. This situation may be restricting the expansion of provider networks serving veterans.

Barriers Resulted in Excessive Wait Times

The access barriers encountered by veterans had a significant effect on the success of the program. Our analysis of the TPAs' self-reported data from November 1, 2014 through September 30, 2015 revealed veterans participating in Choice waited an average of 45 days for care. This is 15 days longer than VHA's established goal of having patients seen within 30 days. Of the two TPAs contracted to administer the program, Health Net averaged 40 days and TriWest averaged 48 days. We did not review individual patient cases to determine if harm occurred due to veterans waiting for treatment in excess of the 30-day standard.

Table 2 shows the number of days it took Health Net and TriWest to complete a Choice appointment in each of the three major phases of the appointment scheduling process.

Table 2. Timeliness by TPA

Process	Health Net	TriWest	Combined*
Authorizing	18 days	27 days	24 days
Processing	8 days	8 days	8 days
Scheduling	14 days	13 days	13 days
Total	40 days	48 days	45 days

Source: TPAs' monthly reports from November 1, 2014 through September 30, 2015

* Combined values represent weighted average between the two contractors.

Before receiving an appointment with a network provider, veterans had to first navigate through Choice's authorizing and processing procedures, such as responding to TPA call centers and not having the assistance of VA staff with the referral process. The veteran has significantly more responsibility to manage his or her own care under Choice.

These procedures involve eligibility reviews, decisions to opt into the program, and transfer of medical documentation by VHA to the TPA. As shown in Table 2, these two processes averaged 32 days—2 days longer than VHA's standard for completing an appointment within 30 days.²¹ Veterans waited an additional 13 days on average to receive care once the TPA scheduled the appointment, for a total wait of 45 days from the point at which they opted into receive care.

**Barriers
Resulted
in Low
Utilization**

Our analysis of the VCL from November 1, 2014 through September 30, 2015 showed that VHA identified approximately 1.2 million instances where veterans could not receive appointments at VHA medical facilities within 30 days. During the same period of time, about 283,500 veterans who were waiting over 30 days for medical care at a VHA facility opted into Choice according to TPAs' monthly reports and 149,000 of these veterans who opted in received an appointment with a Choice provider.

²¹ In Table 2, adding the number of days "Authorizing" (24 days) to the number of days "Processing" (7 days) shows that there were an average of 32 days of administrative tasks that took place prior to creating an appointment.

We calculated a 13 percent utilization rate for Choice based on the number of Choice appointments that were provided (149,000) compared to the number of veteran appointments that were eligible to receive care (1.2 million) (as shown in the VCL). In his response found in Appendix C, the Under Secretary for Health expressed reservations with this methodology stating, VHA calculated utilization only on those veterans who have opted into the program. In our opinion, had we limited our scope to veterans opting in, we could not address barriers veterans face when trying to access Choice—including barriers that prompted them to not participate in the program.

When considering the approximately 283,500 veterans waiting over 30 days from treatment at VHA medical facilities who contacted a TPA to opt into Choice for treatment, 53 percent of them were able to schedule an appointment and receive treatment, 13 percent had their authorizations for care returned to VHA, and 35 percent had authorizations for care that were still pending an appointment as of September 30, 2015.

Table 3 shows the number of veteran appointments Health Net and TriWest provided compared with how many veteran appointments were needed on the VCL.

Table 3. Choice Utilization by TPA

Process	Health Net	TriWest	Combined
Veteran Appointments Needed on the VCL	693,235	466,428	1,159,663
Choice Appointments Provided by TPA	48,025	101,352	149,377
Utilization Percent	7 percent	22 percent	13 percent

Source: Choice Data Summary from November 1, 2014 through September 30, 2015

VHA also sent contract noncompliance letters to the TPAs highlighting deficiencies within the TPAs' networks for physical therapy, neurology, gastroenterology, and colonoscopy services.

Table 4 shows the number of veteran appointments by medical services needed on the VCL with waits of over 30 days for treatment at VHA medical facilities and the number of Choice appointments provided.

Table 4. Choice Utilization by Top Medical Services Needed

Category of Care	Veteran Appointments Needed on VCL	Choice Appointments Provided	Utilization Rate
MRI*	25,836	7,601	29 percent
Physical Therapy	56,723	16,187	29 percent
Orthopedics	62,549	13,892	22 percent
Ophthalmology	62,734	12,990	21 percent
Neurology	31,572	6,093	19 percent
Dermatology	49,736	7,087	14 percent
Cardiology	26,558	3,565	13 percent
Optometry	123,860	15,278	12 percent
Gastroenterology	35,684	4,320	12 percent
Urology	31,366	3,424	11 percent
Podiatry	61,655	5,614	9 percent
Audiology	52,317	2,363	5 percent
Mental Health	52,042	1,782	3 percent
Primary Care	183,194	5,122	3 percent

Source: Choice Data Summary from November 1, 2014 through September 30, 2015

* Magnetic Resonance Imaging

VACAA appropriated \$5 billion to address primary care, mental health, gastroenterology, and women’s health staffing needs within VHA medical facilities. This funding was provided on top of the \$10 billion VACAA authorized for medical care outside of VHA through Choice. Primary Care and Mental Health Services were among the lowest utilized at only 3 percent.

Administrative Costs

Of the \$10 billion appropriated for Choice, \$300 million was set aside to administer the program and \$9.7 billion to provide medical care. From November 2014 through September 2015, VHA spent \$164.9 million in implementation and administrative fees or 55 percent of the \$300 million. VHA spent \$155.5 million of the \$164.9 million in Choice administrative funds on program startup costs, i.e., to issue Choice Cards, create provider

networks, and establish Choice call centers. The remaining \$9.5 million²² of administrative funds was spent on the day-to-day administration of Choice. For the same period, VHA obligated \$412.9 million for medical care provided during the first eleven months of the program, of which approximately \$16 million was expended during that period. Table 5 shows obligations and expenditures for the eleven months of the Choice Program through September 30, 2015.

Table 5. Choice Obligations and Expenditures from November 1, 2014 through September 30, 2015

Funding Use	VACAA	Obligated	Spent
Choice Administrative	300.0 million	\$339.8 million	\$164.9 million*
Choice Medical Care	\$9.7 billion	\$412.9 million	\$16.0 million
Hepatitis C and Emergency Care		\$2.7 billion	\$518.1 million
Totals	\$10.0 billion	\$3.5 billion	\$699.0 million

Source: Financial Management System 887 Obligations report and 827 General Ledger report through May 2016. (dollar amounts rounded to nearest \$100 million)

VHA has obligated a total of approximately \$6.0 billion of VACAA funding through the end of May 2016. Of the \$6.0 billion in obligations, VHA obligated more than \$3.0 billion for Choice medical care and almost \$2.7 billion for Hepatitis C Treatment and Emergency Care in the Community outside of Choice.²³ Additionally, VHA obligated about \$275 million for establishing and administering Choice. The Under Secretary for Health noted in his response to this report that “administrative costs represent less than 10 percent of total obligations as of May 2016”. When we compare the amount obligated for administrative purposes versus medical care, approximately 8.3 percent of Choice Program funds were obligated for administrative purposes.

When comparing the amount of Choice expenditures during the same period, approximately \$206 million of the \$513 million (40 percent) in expended

²² Difference due to rounding

²³ VA obligated \$2.7 billion of \$3.3 billion it was allowed to reallocate outside of Choice under the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. These obligations were made to address a projected \$2.5 billion shortfall in VA’s Care in the Community Program identified in FY 2015 and to provide veterans with costly Hepatitis C drugs. These costs were not included in our calculation of Choice expenditures because this use was not originally authorized by VACAA.

funds were spent on establishing and administering the program and \$306 million (60 percent) were spent on medical care for veterans from November 2014 through May 2016.²⁴ The remaining \$1.6 billion, reallocated outside of Choice in 2015, has been used for Hepatitis C Treatment and Emergency Care in the Community. Table 6 reflects the total obligations and expenditures for the program through May 31, 2016.

Table 6. Cumulative Choice Obligations and Expenditures from November 1, 2014 through May 31, 2016²⁵

Funding Use	VACAA	Obligated	Spent
Choice Administrative	300.0 million	\$275.4 million	\$206.3 million
Choice Medical Care	\$9.7 billion	\$3.0 billion	\$306.4 million
Hepatitis C and Emergency Care		\$2.7 billion	\$1.6 billion
Totals	\$10.0 billion	\$6.0 billion	\$2.1 billion

Source: Financial Management System 887 Obligations report and 827 General Ledger report for May 2016 (dollar amounts rounded to nearest \$100 million)

Conclusion

During the first 11 months of Choice implementation, veteran utilization of the program was low, even using different methodologies for calculating usage. This was primarily due to the processes VHA designed to authorize and schedule care, which were cumbersome and time consuming. Veterans waited longer for authorizing and processing (32 days) than to see a provider after the appointment was scheduled. Without more efficient processes, veterans will continue to experience barriers to accessing the program. At the time of our review, VHA was planning a replacement to the PC3/Choice contracts. For this new contract effort to be successful, VHA will need to improve estimates for demand for purchased care in order to define its network provider requirements. This will encourage the appropriate mix of network providers are available in the specialties and geographic locations where they are needed. In addition, VHA needs to reduce administrative burdens placed on network providers and ensure providers' claims are

²⁴ Expenditures based on payments issued from the U.S. Treasury from the Choice funds, not the amount obligated.

²⁵ Obligation and expenditure totals are provided through May 31, 2016 in response to the Under Secretary for Health's comments that as of May 31, 2016 administrative costs represented less than 10 percent of total obligations.

reimbursed in a timely manner so veterans are not placed at financial risk for the care they receive and participating providers do not leave the network.

Recommendations

1. We recommended the Under Secretary for Health streamline processes and procedures for accessing care under the Veterans Choice Program.
2. We recommended the Under Secretary for Health develop accurate forecasts of demand for care purchased in the community.
3. We recommended the Under Secretary for Health simplify requirements for network providers to bill for services under the Veterans Choice Program.
4. We recommended the Under Secretary for Health ensure eligible veterans are not financially liable for the full cost of treatment authorized under the Veterans Choice Program.
5. We recommended the Under Secretary of Health ensure community providers are paid in a timely manner under the Veterans Choice Program.
6. We recommended the Under Secretary for Health review the Veterans Choice Program to determine if growth of provider networks is being limited by allowing reimbursement below Medicare rates.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendation 1 by November 2016, Recommendation 2 in August 2016, and Recommendation 3 in October 2016. He stated that Recommendations 4, 5, and 6 were completed. The Under Secretary for Health's entire verbatim response is located in Appendix C.

OIG Response

The Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. As of November 2016, VHA had not provided us the evidence necessary to close Recommendations 2, 4, 5, and 6. Once the evidence is received, we will examine the evidence and determine if VHA's actions are sufficient to close the recommendations.

Appendix A Background

Veterans Choice Program Relationship to Patient- Centered Community Care

Choice was preceded by the PC3 Program. In September 2013, VA awarded the initial PC3 contracts to Health Net and TriWest as a supplement to the NVC Program. The contracts totaled approximately \$5.1 billion for Health Net and \$4.4 billion for TriWest. The PC3 Program began health care delivery in January 2014.

PC3 is a VHA nationwide program that offers health care to eligible veterans through service contracts when the local VHA medical facilities have exhausted options for purchased care and cannot readily provide care due to lack of available specialists, long wait times, geographic inaccessibility, or other factors. PC3 provides eligible veterans with access to Primary Care and Mental Health Care, inpatient and outpatient Specialty Care, limited emergency care, and limited newborn care for enrolled female veterans following delivery.

In October 2014, VA amended the PC3 contracts with Health Net and TriWest to include administration of Choice. The contract amendments were valued at \$300 million and required the contractors to perform the following administrative tasks:

- Print and distribute Choice cards to all eligible veterans
- Provide a high-quality network of providers
- Establish call centers to assist veterans
- Schedule appointments with network providers
- Provide medical documentation to VHA following non-VA health care

Eligibility

VACAA (as amended) requires veterans enrolled in VA's health care system to meet one of the following criteria:

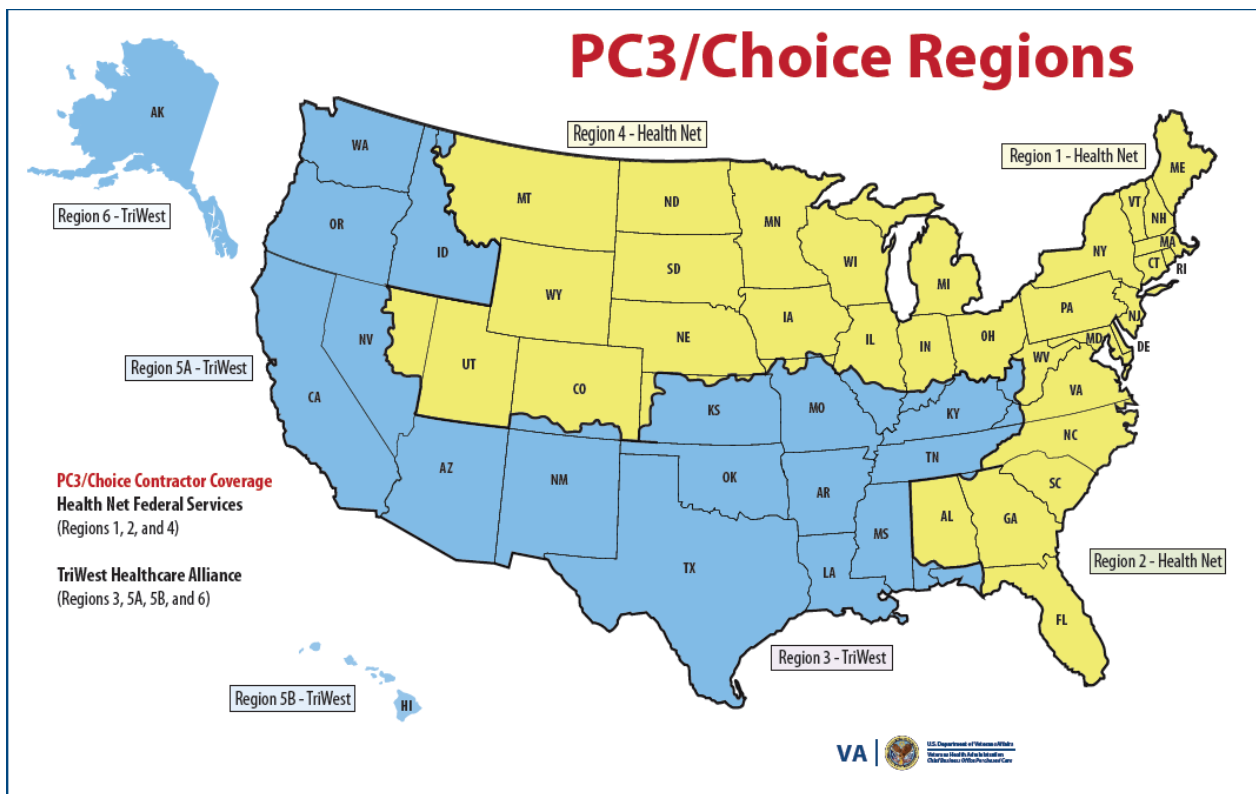
- Attempts to schedule an appointment with VA under Title 38 United States Code (Chapter 17) but cannot be seen within VHA's wait-time goal of 30 days
- Resides more than 40 miles from a VHA medical facility
- Resides less than 40 miles from the VHA medical facility and must travel by air, boat, or ferry to reach such a facility
- Resides less than 40 miles from the VHA medical facility and faces an unusual or excessive burden in accessing such a facility
- Resides in a state without a VHA medical facility

Third-Party Administrators

Health Net and TriWest, the two TPAs, were responsible for the daily administration of Choice. These TPAs were responsible for establishing networks of non-VA providers to meet the medical needs of eligible veterans. TPAs are also responsible for establishing call centers, scheduling appointments, and coordinating the transmission of medical documents between VHA and non-VA providers.

TPAs provide service coverage through six service regions that span the entire continental United States, Alaska, Hawaii, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands. Figure 2 shows TPA coverage areas.

Figure 2. Choice Coverage Areas by Region and TPA



Source: VHA's Chief Business Office

Original Process for Obtaining an Appointment Under Choice

The Choice process starts when VHA determines the veteran cannot be seen at a VHA medical facility within 30 days of his or her preferred date or the clinically appropriate date. Once identified, veterans are added to the VCL.

After adding the veteran to the VCL, VHA informs the veteran he or she is eligible for treatment through Choice and must contact the TPA to utilize the benefits. Staff at the local VHA medical facility creates a Choice authorization that defines the scope of care and gathers medical documentation necessary to coordinate the treatment with a provider outside

of the VHA system. This information is transferred to the TPA through a portal used to exchange information electronically between the two parties.

Once the veteran contacts the TPA, the TPA explains the program benefits and potential costs. If the veteran chooses to opt into Choice, the TPA assists the veteran in scheduling an appointment with a provider in the TPA's network that is within the scope of the Choice authorization. However, the TPA can delay scheduling the appointment until all necessary medical documentation is received from VHA through the portal.

If the veteran chooses not to accept the appointment being offered by the TPA, the Choice authorization is returned to VHA. VHA documents the veteran's decision to not accept the Choice appointment and the veteran retains the scheduled VHA appointment. These procedures were later modified to require VHA and the TPA to contact the veteran to facilitate the opt-in and scheduling processes.

Appendix B Scope and Methodology

Scope

We conducted our review work from August 2015 through May 2016. The review included an assessment of VHA implementation efforts over Choice at eight VHA medical facilities.

Methodology

To effectively assess implementation of Choice at the local VHA medical facility level, we visited the Atlanta VA Health Care System and seven other randomly selected VHA medical facilities. The Atlanta VA Health Care System was selected because of issues raised there by the Chairman of the Senate Committee on Veterans' Affairs in his letter to the OIG. For the other seven stations, using the number of veterans on the VCL on June 1, 2015, we developed a stratified sampling approach and randomly selected VHA medical facilities from each stratum. Table 7 shows the results of our stratified random sample.

Table 7. Selected VHA Medical Facilities by Stratum

Stratum	Veterans on VCL	Selected Station
High	More than 20,000	VA Greater Los Angeles Healthcare System, CA VA Eastern Colorado Health Care System, CO North Florida/South Georgia Veterans Health System, FL
Medium	4,000 to 20,000	South Texas Veterans Health Care System, TX VA Salt Lake City Health Care System, UT
Low	Less than 4,000	John J. Pershing VA Medical Center, MO Kansas City VA Medical Center, MO

Source: VA OIG sample of veterans on the VCL as of June 1, 2015

The review focused on VHA's efforts to ensure veterans were made aware of Choice and identifying any potential barriers to the program. Additionally, we reviewed contractor-provided monthly reports from November 1, 2014 through September 30, 2015, to identify average wait times for multiple stages of the Choice process including authorization return, scheduling of Choice appointment, and veteran attainment of treatment. To determine authorization wait times, we used contractor reports, comparing dates for times when the veteran opted into the program, when the authorization was created, when the appointment was scheduled or returned, and when the appointment occurred. This work was performed only for Choice authorizations for veterans who were waiting over 30 days for treatment at a VHA medical facility.

In addition to measuring authorization wait times, we determined how many 30-day authorizations were scheduled, returned, or incomplete. An authorization was determined to be complete if it had a scheduled appointment and was not later returned. A returned authorization was one with an authorization return date. Lastly, an authorization was determined to be incomplete if it did not have an appointment date, a return date, nor a medical document return date.

To calculate utilization of Choice, we determined the number of veterans who received appointments through Choice when VHA was unable to schedule them an appointment within 30 days. We compared this total number with the number of veterans eligible for Choice on the VCL to calculate veteran utilization of the program.

Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Soliciting the OIG's Office of Investigations for indicators
- Reviewing proposals to ensure they met selection requirements
- Reviewing medical documentation to ensure veterans received treatment for services that were authorized

We did not identify any instances of fraud during this audit.

Data Reliability

To test the reliability of data on the VCL, we compared 30 veterans' documents from our sample with VHA medical documents to verify that veterans on the VCL were eligible for the program. We concluded that the data were sufficiently reliable for our review's objective.

To test the reliability of the data we used from both TPAs' monthly reports, we reviewed 30 completed appointments from each TPA's monthly reports

to determine if there was sufficient evidence within VHA systems to support the veteran had received the care authorized. We compared the date of the completed appointment from the monthly reports with notes in the medical documentation. We concluded that the contractors' monthly reports data were sufficiently reliable for our 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 Evaluation*.

Appendix C Under Secretary for Health—Comments

Department of Veterans Affairs Memorandum

Date: August 10, 2016

From: Under Secretary for Health

Subj: OIG Draft Report, Veterans Health Administration, Review of Implementation of the Veterans Choice Program (7701521)

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

1. Thank you for the opportunity to review the draft report. I concur with the findings and recommendations and provide the attached action plan for recommendations 1 through 6.

The following paragraphs will describe improvement VA has made to the Veterans Choice Program (VCP) during and after the review performed and limitations VA has found in the report.

2. **Background**

The Choice Act, which included the VCP, was passed in August of 2014, to help Veterans access timely health care both within the Department of Veterans Affairs (VA) and in the community, requiring VA to implement a new national program within 90 days. The short timeline created many challenges for Veterans, community providers, and VA. VA reached out to private sector organizations to assist with rapidly standing up and administering this new, complex program, but the aggressive timeline greatly limited private sector interest. VA's only viable option was to modify previously existing contracts that were not originally designed to handle the scale, scope, and complexity of VCP. In addition to the tight timeline and limitations of contract modifications, the Choice Act significantly changed the way VA operated both internally and with the community.

3. **Key Observations and Considerations**

There are a number of items within the report that deserve clarification and further consideration, as changes occurred in the program after some portions of the study were completed:

First, examining the proportion of administrative costs against medical costs at the beginning of a program presents a higher administrative to medical cost ratio, since start-up costs are expected at the beginning of any program. On page 3, the report states that more money has been spent on administration of the program rather than medical costs. This is no longer the case, as of May 2016, administrative costs represent less than 10 percent of total obligations. VA

- monitors both obligations and expenditures, since the timeframe to capture expenditure information can be many months after obligations are recorded. First, the community provider must deliver care. Then the community provider must prepare and bill the contractor (Health Net or TriWest). Health Net or TriWest pays the community provider, after that, they must bill the VA. By the time VA receives and pays the bill (resulting in documentation of an expenditure), many months may have passed since the care was originally authorized and obligated. This time difference results in variations in the proportion of costs spent on administration versus medical care.
- Second, on page 11, the report states that utilization of Choice is low based on the eligible population. However, it is important to note that this program is designed to give Veterans a choice. Eligible Veterans have the option to opt-in or opt-out of the program. We calculate utilization only using those Veterans who have opted into the program and since the start of the program we have seen a dramatic increase in utilization. From October 2015 to March 2016, authorizations for the Choice Program have increased 103 percent. Relatedly, almost 1 million unique Veterans have received or are receiving care under Choice as of August 1, 2016. This increase in utilization is in part related to changes to the Choice contracts. On November 3, 2015, VA implemented a modification to the Choice contracts resulting in the contractors performing outbound calls to Veterans eligible based on wait time to ensure maximum participation. Prior to that date, Veterans had to call the contractor, resulting in lower utilization. Additionally, in March 2015, a

Veterans of Foreign Wars (VFW) survey on the Choice Program found that 47% of survey participants who were offered Choice reported that they chose to retain their care in VA, rather than using Choice. (http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWInitialReportonVeteransChoiceImplementation.pdf). The reasons varied from preferring to get care in the VA to the cost of Choice when using the program for non-service connected care. Since the law requires Veterans with other health insurance to pay a portion of their non-service connected care, some Veterans have opted out of the using the program. The VFW survey provided early feedback on the use of the Choice Program and demonstrated that not all Veterans choose to use the program for a variety of reasons. Therefore our analysis focuses on those Veterans who choose to use the Choice Program.

- Lastly, it is important to recognize the study was conducted early in the implementation of the Choice Program and major changes have occurred since the end of the study period. For instance, the implementation of the contract modification that required the contractor to make outbound calls to Veterans eligible due to wait times was effective November 3, 2015. The regulations resulting from the public laws that were enacted in May and July 2015 were published December 1, 2015. These regulations allowed VA to make many improvements in the program that removed some of the administrative burdens (such as expanding the episode of care from 60 days up to one year) and made more Veterans eligible for Choice (through removal of the enrollment date and other changes in the eligibility criteria). In late February 2016, VA and the contractors completed a modification that decoupled the receipt of medical records from payment to the contractors. This step ensured that community providers were able to receive payments for their services more timely. All of these steps contributed to increased utilization and program improvements since the conclusion of the study.

4. Improving Community Care

VA is committed to improving Community Care for Veterans, community providers, and VA employees. We want to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers and VA staff. To achieve this goal, we are taking both a short-term and long-term approach; implementing immediate fixes where we can today, while driving towards a better future state for Community Care. We outlined this approach in our Plan to Consolidate VA Community Care and submitted it to Congress in October 2015. The plan focuses on five key areas that influence a Veteran's health care journey through community care: eligibility, referral and authorization, care coordination, community care network, and provider payments. Customer service, also a priority, envelopes these five areas. In order to implement all the changes outlined in our plan, we need legislative support and funding from Congress.

Recent accomplishments have helped improve the health care experience for Veterans, have strengthened relationships with community providers, simplified processes for VA staff, and increased utilization of community care.

Veterans

- From October 2015 to March 2016, there has been an increase of 40 percent in Community Care authorizations overall. Since the start of the Veterans Choice program we have seen a dramatic increase in VCP utilization. From October 2015 to March 2016, authorizations for the Choice Program have increased 103 percent for Choice and other programs.
- As of May 2016, the Choice Provider Network has grown by 85 percent. In April 2015, the network had 191,237 providers and facilities contracted. As of May 31st, 2016, the network has 353,674 providers and facilities contracted.
- To increase Veterans access, VA is using VCP Provider Agreements to partner directly with local community care providers to deliver specific services when the VCP contractors are unable to schedule an appointment within the contract requirements or when specific services are not offered by the VCP contractors.
- We are proceeding with a new acquisition to replace the existing VCP contracts. We have released a draft Project Work Statement (PWS) and a Draft Request for Proposal (RFP). We are analyzing public comment and feedback on the draft RFP to prepare for the release of the final RFP. For this new acquisition to be successful, VA will need to ensure our recommended legislative changes are addressed in a timely manner.
- VA is working to resolve instances of improper billing, assist providers with delayed payments, and work to expunge adverse credit reports that are a result of delayed payments. On April 15, 2015, the Customer

Service Center (CSC) began taking calls from Veterans and providers to resolve debt collection issues resulting from inappropriate or delayed Choice Program billing

- To contact VA's Adverse Credit Reporting (ACR) hotline call 1-877-881-7618, press 1. The ACR hotline is open from 9 a.m. to 5 p.m. Eastern Standard Time.

Providers

- VA implemented a joint VA/Contractor Provider Rapid Response Team to address payment issues. We are committed to working closely with our contractors, implement improvements and ensure timely and accurate payment to our community providers. Since its inception the Provider Rapid Response Team has resolved over 50 cases.
- In order to expedite payment to community providers, VA modified the contract with TriWest and Health Net so that payment for services was decoupled from submission of medical records. Ensuring our providers are paid timely leads to more providers joining the network, increasing access for Veterans.
- Collaboration with community providers lead to VA streamlining the medical record submission process by reducing and standardizing what portions of the medical record must be returned, ensuring VA receives the records it needs, and moving towards industry standard enabling community providers to more easily work with VA.
- TriWest increased their auto-adjudication of claims, increased the number of providers submitting electronic claims, and began a new data management system to promote efficiencies and reduce data errors leading to faster more accurate claims payments.
- Health Net focused on improvements to customer service and prompt payment, using Lexis Nexis to standardize data and reduce reporting problems. They also implemented the use of Availity™ Claim Status Tool which allows all providers to view the same results found on a standard Explanation of Benefits claim status.

5. Legislative Needs

VA has partnered with Congress on important adjustments to the initial law. Since passage in 2014, the Veterans Access, Choice and Accountability Act (Choice Act) has been amended four times and the contract modified over 20 times to facilitate needed improvements. The most recent amendments provided benefits that changed the episode of care from 60 days to 1 year, phased implementation of provider types to mental health and treatment facilities.

6. We have four immediate legislative needs in order to begin implementation. These are:

a) Increasing Veterans access to community care providers through the expansion of provider agreements: Contracts create unnecessary administrative burdens for some community providers. Our solution is provider agreements. Our outcome would be a larger provider network that would increase access to care for Veterans.

b) Eliminate confusion for Veterans and community providers by streamlining when and how much VA will pay for health care services by having VA be the primary payer: Inconsistency of VA as primary or secondary payer creates confusion for Veterans and community providers. Our solution is becoming the primary payer. The outcome will be more timely and consistent provider payments.

c) Obligation of funding: Obligating funding at the time of authorization leads to inaccurate accounting. Our solution is obligation of funding at the time of payment. This will improve accounting of community care funds.

Increase Veterans access to care through funding and funding flexibility: VA Community Care is subject to unnecessary funding constraints. Our solution is funding flexibility; one account for all VA Community Care that supports eligibility criteria established by Congress. This will ensure eligible Veterans can access community care and increase funding transparency

7. Additional Information

VA is using the input from OIG, the Government Accountability Office (GAO) and other advisory groups to identify root causes and to develop critical actions that will improve the VCP. VA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the VA health care system.

8. We are dedicated to sustained improvement in the GAO high risk areas. The recommendations in this report apply to high risk areas 1 (ambiguous policies and inconsistent processes) and 5 (unclear resource needs and allocation priorities). The changes we have made so far to streamline our policies and procedures have already begun to ensure consistency, oversight and accountability and to improve access to the VCP for our Veterans.
9. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at VHA10E1DMRSAction@va.gov.

(Original signed by)

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Review of Implementation of the Veterans Choice Program (VCP)

Date of Draft Report: May 6, 2016

Recommendations/ Actions	Status	Completion Date
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Recommendation 1: We recommend the Under Secretary for Health streamline processes and procedures for accessing care under the Veterans Choice Program.

VHA Comments: Concur.

This recommendation is related to Government Accountability Office (GAO) High Risk Area 1 (ambiguous policies and inconsistent processes). In October 2015, the Department of Veterans Affairs (VA) submitted *the Plan to Consolidate Community Care Programs* to Congress. The document outlined our plan to consolidate VA's multiple community care programs to improve access to health care. One of the plan's primary goals is to greatly streamline our processes and clarify policies to establish a single program that is easy to understand, simple to administer, and meets the needs of Veterans, community providers, and VA staff.

The new Community Care Program (CCP) will include some aspects of the current Veterans Choice Program (VCP) (Section 101 of the Veterans Access, Choice, and Accountability Act (The Choice Act), Public Law 113-146, as amended) and incorporate additional elements designed to improve the delivery of community care. The new CCP will reflect streamlined processes and procedures across the five touch points of a Veteran's health care journey: Eligibility, Referral and Authorizations, Care Coordination, Community Care Network, and Provider Payments. In addition, the CCP will incorporate enhanced customer service practices to support each of these areas. Clearer guidelines, infrastructure, and processes will improve Veterans' overall experience with VA and provide greater choice and access to both VA and community health care services.

While we wait for Congress to pass Veteran eligibility and other legislative enhancements in support of *the Plan to Consolidate Community Care Programs*, VA continues to improve Veteran access to community care. In April 2016, VA began to pilot the use of provider agreements. These agreements will enable VA facilities to partner more directly with local care providers when our third-party administrators (TPAs), Health Net and TriWest, are unable to schedule an appointment or when needed services are not covered by their network. The use of provider agreements to augment the existing VCP network will help ensure Veterans get the care they need while we continue to work towards a new CCP.

VA is also working to remedy the issues specific to scheduling and care coordination pointed out in the OIG report. Specifically, VA is planning to transition Choice care management activities, including appointment scheduling and care coordination, from VCP contractors to VA. Following completion of modifications to their contracts, Health Net and TriWest will no longer provide these services. Instead, these services will be performed by local VA medical facility staff with oversight by the Office of Community Care. This will enable VA staff to communicate and work more closely with Veterans and VCP providers to schedule appointments and, in turn, will allow Health Net and TriWest to focus their efforts on provider recruitment, relations, timely claims submissions and provider payment. The Alaska VA Healthcare System will serve as the initial site for implementation of the VA-performed Choice care management processes. Staff at the Alaska facility will participate in process refinement as necessary to document best practices.

By allowing VA to take ownership of the care management activities and implementing provider agreements, VA will effectively streamline the process for Veterans to access care under VCP by reducing the number of touchpoints for scheduling appointments. Additionally, by removing the VCP contractors from the process, these actions will reduce the amount of time spent attempting to reach the Veteran (who will already be in contact with the VA facility) and coordinate appointment availability.

VHA Office of Community Care will provide the following documentation at completion of this action:

- Copy of the *Plan to Consolidate Community Care Programs*, October 2015;
- VA Community Care VCP Provider Agreement Information Sheet, April 2016;

- Copy of the contract modification that transitions Choice care management activity to VHA; and
- White paper analysis of Alaska Choice care management implementation activities and outcomes.

Status	Target Completion Date
In Process	November 2016

Recommendation 2: We recommend the Under Secretary for Health develop accurate forecast of demand for care purchased in the community.

VHA Comments: Concur.

This recommendation is related to GAO High Risk Area 5 (unclear resource needs and allocation priorities). The Office of Community Care will continue to work with our third-party administrators to meet current demand profiles and implement actions outlined below to better understand network capacity and capability requirements.

The VA Enrollee Health Care Projection Model projects Veteran enrollment, utilization and expenditures 20 years into the future for over 90 categories of health service categories (e.g., ambulatory care, mental health, prosthetics, etc.). The model is Veteran centric and based on enrollee characteristics and demographics including geography, actual experience, and policy assumptions. Agility is a key feature of the model which means it can be easily updated regarding future policy or legislative decisions. The base year 2015 VA Enrollee Health Care Projection Model has been updated to include community care projections. These projections are being used to inform development or expansion of the current VCP Network and future oriented acquisition strategies. The projections include utilization of modeled services by approximately 150 geographic submarkets, based on projected need for health care services and historical patterns of purchased care. As additional years of data are made available, as VCP changes, and as the VA health care system evolves, the model's projections will continue to be refined.

Currently, VA is planning an acquisition to replace the existing VCP contracts. As part of the planning for this acquisition, the VHA Office of Community Care is using the projection model to more accurately forecast the demand for prospective bidders. A drafted Request for Proposal (RFP) has been shared widely for comment by industry partners, Veteran Service Organizations (VSOs), Veterans and other stakeholders. The finalized RFP will incorporate industry standards and best practices as well as reflect information from Veterans, providers, and VA staff experiences with Patient Centered Community Care (PC3), VCP, and Non-VA Care (NVC) programs. The RFP includes information on VA's National, local-level, and specialty area capacity and capability needs. The RFP also defines the requirements for a robust, high-performing provider network.

VHA's Office of Community Care will provide the following documentation at completion of this action:

- Final RFP – VA Community Care Network

Status	Target Completion Date
In process	August 2016

Recommendation 3: We recommend the Under Secretary for Health simplify requirements for network providers to bill for services under the Veterans Choice Program.

VHA Comments: Concur.

This recommendation is related to GAO's High Risk Area 1 (ambiguous policies and inconsistent processes). VHA acknowledges that administrative burdens, confusing instructions, and the subsequent delayed provider payments have caused undue stress for Veterans and network providers alike.

Recent VA actions, such as the elimination of medical documentation as a condition for payment, were announced on March 1, 2016. VA also announced a decrease in the amount of overall medical documentation to be returned to VA, further streamlining administrative requirements. VA does still require medical documentation be submitted for purposes of care coordination. Coincident with these changes, both Health Net and TriWest have also made operational improvements to ease provider claim submissions and assist with claim follow-up. For example, Health Net implemented the Availity™ Claim Research Tool that allows providers to check the status of their claims. Results are available in real-time and provide the equivalent of an Explanation of Benefits.

The VHA Office of Community Care has developed targeted communication products to improve understanding of provider billing and payment responsibilities, clarify Veteran and Other Health Insurance (OHI) billing practices, and offer guidance to improve the accuracy and timeliness of billing and payments. VA is initiating mailings to community providers reminding them of the process to properly bill claims to ensure timely payment and promoting the use of electronic billing for easier submissions and faster processing. Other guidance is being prepared to ensure that provider bills are directed to the correct payment processing locations – thereby, enhancing the provider's ability to receive a timelier payment.

VHA's Office of Community Care will provide the following documentation at completion of this action:

- Copy of the contract modification that decouples medical documentation receipt from claims payment; and
- VA Community Care VCP Provider Agreement Information Sheet, April 2016; and
- Provider Letter promoting use of electronic billing.

Status	Target Completion Date
In process	October 2016

Recommendation 4: We recommend the Under Secretary for Health create a mechanism to ensure eligible veterans are not financially liable for the full cost of treatment authorized under the Veterans Choice Program.

VHA Comments: Concur.

This recommendation is related to GAO's High Risk Area 1 (ambiguous policies and inconsistent processes). VA is clarifying policy and pursuing legal action to ensure that eligible Veterans are not financially liable for the full cost of treatment under the VCP.

As long as a Veteran participates in VCP in accordance with the law – getting pre-authorization to see VCP providers and opting into the program, they are not responsible for the full cost of services. However by law, for non-service connected conditions, Veterans may be liable for a portion of the costs not covered by their OHI. This partial liability is called "cost-shares". If the Veteran uses the Choice card outside the parameters of the law, then the Veteran may be financially liable for the full cost of unauthorized care. VA continues to educate Veterans, providers and the public about participation in VCP and proper utilization of the Choice card.

During the first year of the VCP, some providers were billing Veterans for the full cost associated with non-service connected conditions that should have been paid by Health Net or TriWest. Part of the reason this was happening was because providers weren't being paid in a timely manner by Health Net or TriWest. In March 2016, VA modified the contract to decouple medical documentation receipt from claims payment speeding up the payment process. With the contract modification and as Veterans become more proficient at using the VCP, we will see fewer instances where Veterans are being held liable for the full cost of their care.

The Choice Act, Public Law 113-146 as amended, designated that a Veteran authorized to see a VCP provider for a service connected condition will not be held financially liable for any of the cost of treatment authorized. This is because VA is designated as the primary payer for these conditions. However, The Choice Act designates VA as a secondary payer when the authorized care is for a non-service connected condition. Under VCP, the contractors are required to collect OHI (except for Medicare, Medicaid and TRICARE) for a Veteran to use the program. If the care received is non-service connected, the VCP provider must bill the OHI first, prior to billing VA. In these circumstances, the Veteran is responsible for the OHI cost-shares.

VA has also undertaken targeted efforts to help Veterans with unpaid claims for authorized VA community care. In January 2016, VA established an adverse credit reporting hotline to assist Veterans experiencing debt collection issues from inappropriate or delayed VCP billing. VA staff work with medical providers to expunge adverse credit reporting for these Veterans. The hotline (1-877-881-7618) provides an important mechanism to mitigate the detrimental impact and stress that avoidable financial hardships create for Veterans.

VA has been using various tactics to communicate with key stakeholders about strategies to improve VCP—especially those to resolve billing, provider payment and Veteran financial risk. VA has used blogs on Vantage Point and VA Pulse, the Veterans Choice website and Facebook, when appropriate. VA is also continuing to communicate with Veterans, VSOs and academic and Federal partners about these matters. VA Town Hall meetings with employees are being conducted to share developments and important information needed to better assist and support affected Veterans and community providers.

The VHA Office of Community Care will provide the following documentation at completion of this action:

- Copy of the contract modification that decouples medical documentation receipt from claims payment;
- Copy of the *Plan to Consolidate Community Care Programs*, October 2015;
- Copy of March 14, 2016 press release: VA Announces Community Care Call Center to help Veterans with Choice Program Billing Issues; and
- Copy of May 10, 2016 memo from the Deputy Under Secretary for Health for Operations and Management titled: Community Care, including Veterans Choice Program (VCP), Town Halls.

Status	Target Completion Date
Complete	May 2016

Recommendation 5: We recommend the Under Secretary for Health create a mechanism to ensure community providers are paid in a timely manner under the Veterans Choice Program.

VHA Comments: Concur.

This recommendation is related to GAO's High Risk Area 1 (ambiguous policies and inconsistent processes). VA's actions will ensure consistent processes are in place so community providers are paid in a timely manner.

VA recognizes that our current contracts do not define a mechanism to monitor or ensure the timeliness of Third Party Administrator (TPA) payments to providers. These contracts also do not allow VA authority to ensure the TPA pays their network providers in a timely manner. However, the contract modification which eliminated medical documentation as a requirement for payment also requires the TPAs to make payments to providers "within 30 calendar days of receipt of a clean claim." The contract modification also includes language that stipulates that TPAs may not invoice VA for services for which the community provider has not yet been paid.

VA is working with the TPAs, community providers and other partners to address community care billing, claims status and to expedite provider payments, while also ensuring our Veterans continue receiving the care they need. VHA's Office of Community Care has organized a Provider Rapid Response Team. This team is comprised of staff who will work with the network providers to research, resolve and ensure payment delays are resolved expeditiously. Both TPA contractors have taken steps to improve the timeliness and accuracy of their internal payment processes. TriWest has implemented improvements such as increasing auto adjudication, promoting the electronic submission of claims, and developing a new system to reduce data entry errors. Health Net has also focused on improvements to customer service for both Veterans and community providers, and has implemented the use of Lexis Nexis, allowing for more standardized data, and reducing reporting problems with the upfront loading of provider vendor information.

For the longer term, *the Plan to Consolidate Community Care Programs* outlines several improvements to support prompt payment practices like auto-claim adjudication and legislative changes for greater consistency in fee schedules that will improve accuracy and timeliness of claims processing. Appropriate requirements and payment timeliness standards have been included in the draft RFP for the Community Care Network released for industry and public comment:

https://www.fbo.gov/index?s=opportunity&mode=form&id=ceac1b47227f20ade3867c39e629bcc1&tab=core&_cview=1

VHA's Office of Community Care will provide the following documentation at completion of this action:

- Copy of the contract modification that decouples medical documentation receipt from claims payment; and
- Provider Rapid Response Team charter.

Status	Target Completion Date
Complete	May 2016

Recommendation 6: We recommend the Under Secretary for Health review the Veterans Choice Program to determine if growth of provider networks is being limited by allowing reimbursement below Medicare rates.

VHA Comments: Concur in principle.

VHA agrees that there is a strong link between reimbursement rates and the ability to establish robust provider networks. The Veterans Access, Choice, and Accountability Act (The Choice Act) established that rates negotiated with providers shall not be more than the rates paid by Medicare for the same services, with the exception of rural and highly rural areas. The contracts to administer VCP were actually modifications to the Patient-Centered Community Care (PC3) contracts, which set payment rates for many services below the Medicare rate. The two different payment structures for PC3 and VCP caused confusion for community providers and, in some cases, created a disincentive for joining the contracted networks. Since implementing the Hierarchy of Care memorandum in May 2015, utilization of VCP has increased tremendously, while PC3 utilization has dwindled. As a result, Health Net and TriWest are recruiting providers into their networks under the VCP payment structure (i.e., Medicare rates). Over the past year, we have seen the VCP provider network increase from 185,000 providers in 2015 to nearly 290,000 providers now.

Our experience with PC3, VCP, and the tradition Non-VA Medical Care (NVC) programs informed the *Plan to Consolidate Community Care Programs*. In this plan, we propose to consolidate multiple programs into a singular authority, with reimbursement tied to the Medicare reimbursement for like services. Further, based on our experience with these programs, we feel we have a sufficient understanding of the impact of reimbursement rates on provider network growth; performing an additional review would not be beneficial at this time.

VHA's Office of Community Care will provide the following documentation at completion of this action:

- Copy of the *Plan to Consolidate Community Care Programs*, October 2015

Status	Target Completion Date
Complete	May 2016

For accessibility, the format of the original documents in this appendix has been modified to fit in this document.

Appendix D **OIG Contact and Staff Acknowledgments**

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Matthew Rutter, Director Jill Akridge Sophia Demco Chris Enders Todd Groothuis Michael Kelly Issa Ndiaye Melinda Toom Nelvy Viguera Butler
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Appendix E Report Distribution

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