



Testimony

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Representatives

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VA HEALTH CARE

Actions Needed to Improve Monitoring and Oversight of Non-VA and Contract Care

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GAO Highlights

Highlights of [GAO-15-654T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA uses both the Non-VA Medical Care Program and clinical contracts to augment its delivery of care to veterans. GAO has previously highlighted weaknesses in the monitoring and oversight of both non-VA medical care and clinical contracts that remain unresolved.

This testimony is based on three GAO reports issued in 2013 and 2014 and addresses the extent to which VA monitors and oversees its (1) Non-VA Medical Care Program and (2) clinical contracts and contracted non-VA providers working in VA facilities. For all three reports, GAO reviewed relevant requirements and visited a total of 14 VA facilities. For its May 2013 report on the oversight and management of the Non-VA Medical Care Program, GAO reviewed non-VA medical care data from fiscal year 2008 through fiscal year 2012. For its October 2013 report on clinical contract monitoring and oversight, GAO administered a data collection instrument to CORs and reviewed 12 selected clinical contracts. For its March 2014 report on non-VA emergency medical care for veterans' non-service connected conditions, GAO reviewed 128 denied claims.

What GAO Recommends

GAO made 22 recommendations to VA in its prior three reports related to improving (1) data on wait times and cost-effectiveness of non-VA medical care; (2) VA's oversight and monitoring of claims processing; and (3) VA's monitoring of clinical contractors. VA agreed with these recommendations, and has taken action on some, but has yet to fully implement many of them.

View [GAO-15-654T](#). For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

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VA HEALTH CARE

Actions Needed to Improve Monitoring and Oversight of Non-VA and Contract Care

What GAO Found

GAO's recent work has found significant weaknesses in the Department of Veterans Affairs' (VA) monitoring and oversight of its Non-VA Medical Care Program. Through this program, care is provided to veterans by non-VA providers in non-VA facilities. As GAO reported in May 2013, VA did not collect data on wait times veterans face in obtaining care from non-VA providers. Having data on wait times for veterans referred to non-VA providers would help VA better determine if veterans are receiving comparable access to non-VA providers and VA-based providers. In addition, GAO found that VA was unable to analyze non-VA medical care data on all services and charges for an episode of care, which is the combined total of all care provided to a veteran during a single office visit or inpatient stay. As a result, VA cannot ensure that non-VA providers are billing VA appropriately for care or determine whether delivering care through non-VA providers is more cost-effective than augmenting its own capacity in areas of high utilization of non-VA medical care. Moreover, in March 2014 GAO reported that crucial limitations existed in VA's monitoring and oversight of non-VA medical care claims processing. Specifically, VA lacked automated processes for (1) determining whether claims met VA's criteria for payment and (2) notifying veterans when their claims were denied. Instead, these processes relied largely on the judgment and diligence of VA facility-based claims processing staff. For example, GAO found several non-VA medical care claims that were inappropriately denied because VA facility-based claims processing staff processed the claims under the wrong payment authority. Moreover, GAO found that VA's oversight was lacking in key aspects of the claims review process, a factor that allowed inappropriate denials and notification issues to persist.

GAO's recent work has also found significant limitations in VA's monitoring and oversight of clinical contracts and contractors—a method VA uses to bring non-VA providers into VA facilities. As GAO reported in October 2013, contracting officer's representatives' (COR) heavy workloads and inadequate training compromised VA's monitoring of contractor performance. CORs are responsible for monitoring the work of non-VA providers working in VA facilities under a contract once the contract is in place. CORs for 8 of the 12 contracts GAO reviewed in depth reported that the demands of their primary positions at the VA facility have at times prevented them from fully monitoring contract providers' performance. Six of these CORs stated that they could not complete certain elements of their COR responsibilities—such as adequately monitoring contract costs—due to limited time and resources. Robust VA oversight would better ensure that the contract providers deliver high quality care to veterans and fulfill the responsibilities of their contracts. In addition, CORs from the four VA facilities GAO visited noted weaknesses in VA's COR training and GAO's analysis confirmed these limitations. Specifically, GAO found this training focused on teaching CORs to develop contracts that purchase goods and not clinical services. The primary examples in this course included discussions of the contracting process for replacing carpet and making a large computer purchase. In addition, COR training included little information on how CORs should engage in post-award monitoring of clinical contractors.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here today to discuss our work on the Department of Veterans Affairs' (VA) delivery of care through both its Non-VA Medical Care Program and clinical contracts.¹ The majority of veterans enrolled in the VA health care system receive care in VA-operated medical facilities, such as VA medical centers and community-based outpatient clinics.² However, in order to meet the needs of the veterans it serves, VA is authorized to obtain health care services from non-VA providers through both the Non-VA Medical Care Program and clinical contracts.³ These two mechanisms for accessing non-VA providers help to augment VA's delivery of services to veterans in different ways. The Non-VA Medical Care Program allows VA to deliver care to veterans in non-VA facilities, such as physicians' offices and hospitals in the community, and pay for this care using a fee-for-service arrangement.⁴ Clinical contracts are used by VA to bring non-VA providers—such as physicians, pharmacists, and nurses—into VA facilities to provide services to veterans. These contracts can be used to fill vacancies for clinicians in specialties that are difficult to recruit, supplement existing VA capacity by providing additional clinicians in high-volume areas, or fill critical staffing vacancies on a long- or short-term basis. According to VA, every VA facility has at least one clinical contract in place to help supplement the number of providers working in VA medical facilities.

VA's spending on the Non-VA Medical Care Program and the number of veterans receiving care from non-VA providers have both risen significantly in recent years. From fiscal year 2008 to fiscal year 2013, VA spending on non-VA medical care rose from about \$3 billion to about

¹The Non-VA Medical Care Program was previously known as the Fee Basis Care Program.

²VA's health care system includes medical centers, VA-operated community-based outpatient clinics, community living centers (nursing homes), residential rehabilitation treatment programs, and comprehensive home care programs.

³VA obtains the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

⁴For example, VA may utilize non-VA medical care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or when a veteran would have to travel long distances to obtain care at a VA medical facility.

\$4.8 billion. Since 2013, VA has added two new components to its Non-VA Medical Care Program—the Choice Program and Patient-Centered Community Care (PC3).⁵ With the addition of these new components, it is anticipated that the number of veterans seeking care through the Non-VA Medical Care Program will continue to grow. As such, it is increasingly important for VA to incorporate robust oversight and accountability into the administration of the program to address inefficiencies in non-VA medical care delivery highlighted in recent reports by GAO and others.⁶

VA's oversight of clinical contracts used throughout the VA health care system has also been shown to be limited. Previous studies highlighted challenges VA has faced developing and administering its clinical contracts. In recent years, for example, the VA Office of the Inspector General highlighted challenges VA faces in developing its clinical contracts and found systemic weaknesses in the process VA uses to award contracts.⁷ These weaknesses were attributed to VA's decentralized oversight of the initial stages of the contracting process before a contract is awarded to a contractor. In an October 2013 report, we found that VA's oversight of clinical contractors is inadequate once a

⁵The Veterans Access, Choice, and Accountability Act of 2014 provided new authorities, funding, and other tools to help with the reform of the VA health care system. Through this Act, Congress provided \$10 billion in additional funds to VA to under certain conditions expand its ability to provide non-VA medical care to certain veterans, such as veterans that are unable to get an appointment with a VA provider within 30 days of either their desired or clinically appropriate date or live more than 40 miles from the nearest VA facility. This funding is available for VA's use through August 7, 2017 or until its exhaustion, whichever comes first. PC3 is a nationwide VA program that established two nationwide contracts with Health Net and TriWest to establish networks of providers that can provide care through the Non-VA Medical Care Program in a number of specialties—including primary care, inpatient specialty care, and mental health care. Pub. L. No. 113-146, 128 Stat. 1754 (2014).

⁶See GAO, *VA Health Care: Actions Needed to Improve Administration and Oversight of Veterans' Millennium Act Emergency Care Benefit*, [GAO-14-175](#) (Washington, D.C.: Mar. 6, 2014) and *VA Health Care: Management and Oversight of Fee Basis Care Need Improvement*, [GAO-13-441](#) (Washington, D.C.: May 31, 2013). See also, Department of Veterans Affairs Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, 08-02901-185 (Washington D.C.: Aug. 3, 2009). See also National Academy of Public Administration, *Veterans Health Administration Fee Care Program* (Washington, D.C.: September 2011).

⁷See Department of Veterans Affairs Office of Inspector General, *Audit of Veterans Integrated Service Network Contracts*, 10-01767-27 (Washington, D.C.: Dec. 1, 2011) and Department of Veterans Affairs Office of Inspector General, *Audit of VA Electronic Contract Management System*, 08-00921-181 (Washington, D.C.: July 30, 2009).

contract is awarded and contract providers begin caring for veterans in VA facilities.⁸

Today, I will summarize the results of recent GAO work examining weaknesses in the oversight of VA's Non-VA Medical Care Program and clinical contracts. Specifically, I will address the extent to which (1) VA monitors and oversees its Non-VA Medical Care Program and (2) VA monitors and oversees clinical contracts and the work of contracted non-VA providers working in VA facilities.⁹ My comments are based on reports we issued in March 2014 and May 2013 examining the Non-VA Medical Care Program, and October 2013 examining clinical contracts.¹⁰

For the March 2014 report, which focused on VA's administration and oversight of emergency care for conditions not related to veterans' service-connected disabilities provided under the Veterans Millennium Health Care and Benefits Act (Millennium Act) and delivered to veterans by non-VA providers, we reviewed the law, its implementing regulations, and applicable VA policies and guidance to identify applicable requirements for processing these claims.¹¹ We then visited four VA facilities that were selected on the basis of fiscal year 2012 spending totals and geographic location and reviewed VA documents—including 128 emergency care claims for veterans with non-service connected conditions that these four facilities had denied in fiscal year 2012. We also interviewed officials from VA, non-VA providers, and veterans' service organizations.

⁸See GAO, *VA Health Care: Additional Guidance, Training and Oversight Needed to Improve Clinical Contract Monitoring*, [GAO-14-54](#) (Washington, D.C.: Oct. 31, 2013).

⁹Because the Choice Program and PC3 are recently-added components to VA's Non-VA Medical Care Program and we have not reviewed them, this statement will be confined to discussing existing non-VA medical care delivery mechanisms that existed prior to 2013. To date, Choice Program and PC3-related claims represent a small portion of the \$4.8 billion VA currently spends on non-VA provider care.

¹⁰See [GAO-14-175](#), [GAO-13-441](#), and [GAO-14-54](#).

¹¹The Millennium Act authorizes VA to cover emergency care for conditions not related to veterans' service-connected disabilities when veterans who have no other health plan coverage receive care at non-VA providers and meet other specified criteria. See Pub. L. No. 106-117, § 111, 113 Stat. 1545, 1553 (1999) (codified, as amended, at 38 U.S.C. § 1725).

For the May 2013 report, which focused on VA's management and oversight of non-VA medical care spending and utilization, we reviewed relevant laws and regulations, VA policies, and spending and utilization data on non-VA medical care from fiscal years 2008 through 2012. We also interviewed VA officials and examined the non-VA medical care operations at six selected VA facilities that varied in size, services offered, and geographic location. The results of both of these studies cannot be generalized to all VA facilities, but illustrate the serious weaknesses in various aspects of the Non-VA Medical Care Program.

For the October 2013 report, which focused on VA's monitoring and oversight of clinical contracts and contractors, we reviewed relevant laws, regulations, and VA policies. We also interviewed VA officials and examined clinical contract monitoring efforts in place—including an in-depth review of 12 clinical contracts—at four selected VA facilities that varied in the types of clinical contracts used and geographic location. The results of this study cannot be generalized to all VA facilities, but illustrates serious weaknesses in VA's monitoring and oversight of non-VA providers caring for veterans in VA facilities through clinical contracts.

We have made 22 recommendations to VA in these previous reports, and VA concurred with all of them. We are not making any new recommendations at this time. From January to May 2015, we periodically met with VA officials to discuss the status of VA's implementation of the recommendations in these three reports.

The work this statement is based on was conducted in accordance with generally accepted government accounting standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The reports cited provide additional information on our scope and methodology.

Background

Non-VA Medical Care Program

There are two main non-VA medical care delivery methods—preauthorized care and emergency care—that are approved using two different processes. The first, preauthorized care, is approved in advance by VA facility officials. VA may authorize veterans to seek care from non-VA providers for a number of reasons, including when (1) wait times for appointments at VA facilities exceed VA standards; (2) the distance veterans must travel to VA facilities is impractical for the veteran; and (3) VA facilities do not offer the medical services the veteran needs. Preauthorized care accounts for the majority of spending and utilization (about 60 percent of spending and about 88 percent of utilization) for the Non-VA Medical Care Program. The second, emergency care, is not typically approved in advance by VA facility officials and has certain criteria that must be met in order for VA to approve reimbursement for the non-VA provider. (See table 1.)

Table 1: Types of Non-VA Medical Care Claims and Relevant Payment Authority

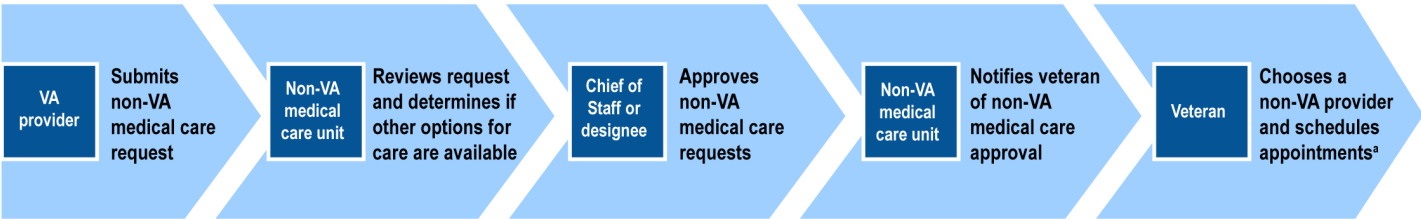
Type of claim	Description and relevant payment authority
Preauthorized care ^a	Services with prior VA authorization meeting criteria under 38 U.S.C. § 1703 (e.g., cancer treatment, mammography)
Emergency care	Services without VA preauthorization (e.g., heart attack care, treatment of injuries from a motor vehicle crash)
Veterans Millennium Health Care and Benefits Act (emergency care for conditions not related to service-connected disabilities)	Services meeting criteria under 38 U.S.C. § 1725
Emergency care for conditions related to service-connected disabilities	Services meeting criteria under 38 U.S.C. § 1728

Source: GAO analysis of VA policies. | GAO-15-654T.

^aIn certain circumstances, emergency care provided by non-VA providers can be deemed preauthorized if the non-VA providers provide notification of a veteran's admission within 72 hours. Emergency care by non-VA providers may also be preauthorized for veterans receiving medical services in a VA facility or nursing home up to the point that the veteran can be safely returned to the VA facility following the emergency care treatment at the non-VA facility.

Preauthorizing non-VA medical care involves a multistep process conducted by the VA facility that regularly serves a veteran.¹² The preauthorization process is initiated by a VA provider who submits a request for non-VA medical care to the VA facility's non-VA medical care unit, which is an administrative department within each VA facility that processes VA providers' non-VA medical care requests and verifies that non-VA medical care is necessary. Once approved by the VA facility's Chief of Staff or his or her designee, the veteran is notified of the approval and can choose any non-VA provider willing to accept VA payment at predetermined rates.¹³ (See fig. 1.)

Figure 1: Department of Veterans Affairs (VA) Facility Process for Preauthorizing Non-VA Medical Care



Source: GAO. | GAO-15-654T

^aIn some VA facilities the non-VA medical care unit may assist veterans in setting up their appointments with the non-VA provider of their choice.

Regardless of whether a veteran's non-VA medical care was preauthorized or the result of an emergency, the steps for processing payments to non-VA providers are the same. Specifically, the non-VA provider submits a claim to either a Veterans Integrated Service Network (VISN) or a VA facility for payment following the veteran's treatment.¹⁴ In some VISNs, claims processing activities are centralized in a VISN-level

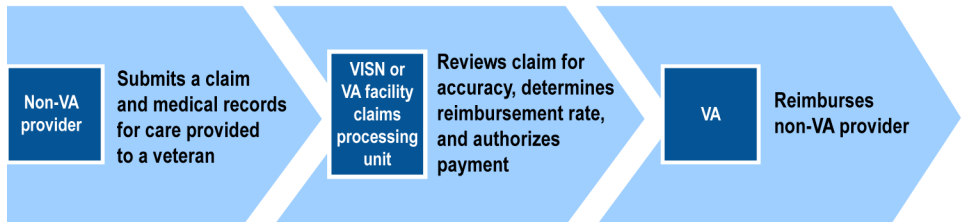
¹²VA uses this same preauthorization process for nonemergency inpatient and outpatient care, dental care, nursing home care, compensation and pension exams, and most pharmacy expenses paid for through the non-VA medical care program.

¹³VA uses this process to preauthorize non-VA medical care from a number of different types of non-VA providers, including community-based hospitals and Department of Defense medical facilities that collaborate with VA facilities to provide some veterans' care.

¹⁴VHA's health care system is divided into 21 areas called VISNs, each responsible for managing and overseeing medical facilities within a defined geographic area. VISNs oversee the day-to-day functions of VA facilities that are within their network. Each VA facility is assigned to a single VISN.

department that is responsible for reviewing claims from non-VA providers, obtaining copies of medical records for veterans' non-VA medical care, and approving payment to non-VA providers. In other VISNs, these claims-processing activities are decentralized and are the responsibility of individual VA facilities. After VA facility or VISN officials review the claims for accuracy, non-VA providers are reimbursed by VA. (See fig. 2.)

Figure 2: Veterans Integrated Service Network (VISN) or Department of Veterans Affairs (VA) Facility Steps for Processing Approved Claims for Non-VA Medical Care



Source: GAO. | GAO-15-654T

Note: In November 2014, VA completed an organizational realignment and reassigned all VA VISN- and facility-based claims processing staff to VA Central Office. However, VA Central Office has not centralized the location of these staff and they continue to work within the VISNs and VA facilities to which they previously reported.

To process all claims for non-VA medical care, VA facilities must enter information into the non-VA medical care claims processing system. This system helps VA facilities administer payments to non-VA providers, as opposed to a system that automatically applies relevant criteria and determines whether claims are eligible for payment. As a result, VA relies on staff in the VISNs and VA facilities that process claims, such as administrative clerks and clinicians (typically nurses), to make decisions about which payment authority applies to the claim and which claims meet the criteria for VA payment.

If VA denies payment for a claim for non-VA medical care, the agency must provide written notice to the veteran and the claimant (usually, the non-VA provider) regarding the reason for the denial and inform them of their rights to request a reconsideration or to formally appeal the denial. If a veteran or non-VA provider has questions about a denied claim, claims should be reconsidered by a supervisor at the same VISN or VA facility that denied the claim. If the denial decision is upheld, the veteran or non-

VA provider has the right to file an appeal through the Board of Veterans' Appeals.¹⁵

VA Clinical Contracting

Both acquisition and clinical staff at VA work together to plan, execute, and monitor clinical contracts at VA. On the acquisition side, contracting officers (CO) are responsible for planning, awarding, and administering contracts on behalf of the federal government. Each CO is authorized to obligate federal funds up to a specified limit and a CO must formally approve all clinical contracts at VA. Common tasks of a CO include developing acquisition planning documents used to begin a clinical contract, conducting market research to determine pricing and availability for a clinical contract, and completing the formal competitive or non-competitive solicitation process for contracts. Each CO works within a network contracting office and is overseen by managers within that office who report directly to VA Central Office. There are 21 network contracting offices throughout VA's health care system that manage all the contracting activities of a single VISN.¹⁶

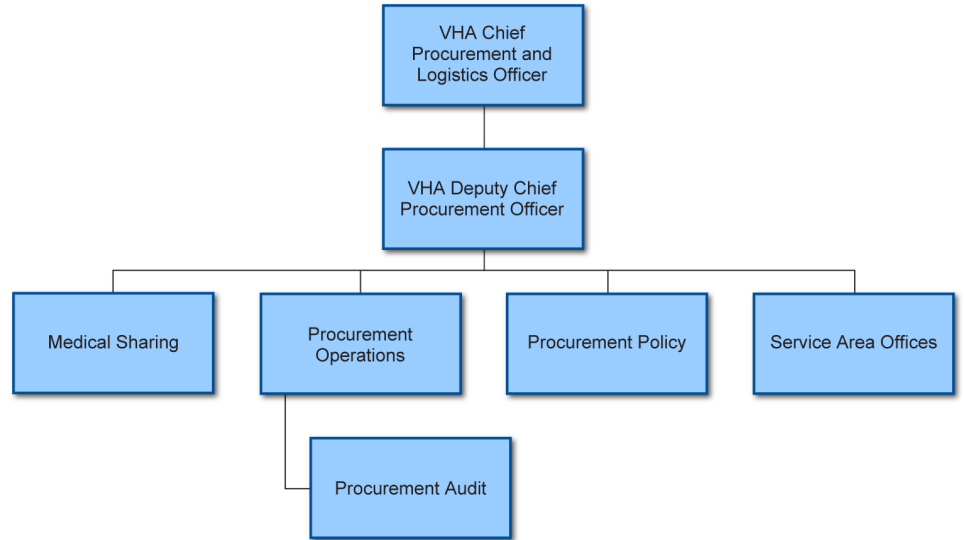
For each VA clinical contract, the CO responsible for the contract designates a contracting officers' representative (COR) at the VA facility to help develop the clinical contract and monitor the contract provider's performance once the provider begins work. Common tasks delegated to the COR include providing input on the performance requirements for the clinical contract, determining how the contract provider's performance will be measured and monitoring performance once work has begun, validating the contract provider's invoices to ensure their accuracy, managing contract modifications, and assisting the CO in resolving any issues that may arise with the contract provider. At VA, CORs are commonly administrative personnel responsible for managing the operations of a specialty care line at a VA facility—such as primary care and surgery—where the contractor will be working. CORs are responsible for maintaining the official record of the contract provider's performance and providing official performance assessments to the CO.

¹⁵Based in Washington, D.C., the Board of Veterans' Appeals is composed of judges experienced in veterans' law. The Board reviews benefit determinations made by local VA offices and issues final decisions on appeals.

¹⁶While network contracting offices manage the contracting activities of a single VISN, they are managed by VA Central Office regional contracting management entities and have no managerial link to VISN leadership.

VA Central Office has primary responsibility for overseeing network contracting offices and manages clinical contracting activities through the Veterans Health Administration (VHA) Procurement and Logistics Office.¹⁷ There are five primary offices within the VHA Procurement and Logistics Office that are responsible for overseeing various aspects of clinical contracting activities and report to VHA's Deputy Chief Procurement Officer. (See fig. 3.)

Figure 3: Organization of the Veterans Health Administration (VHA) Procurement and Logistics Office



Source: GAO analysis of VA information. | GAO-15-654T

Medical Sharing Office. The Medical Sharing Office is responsible for providing guidance to network contracting offices regarding the content and structure of solicitations for clinical contracts and for reviewing several types of clinical contracts. The Medical Sharing Office reviews solicitations of all competitive clinical contracts valued at over \$1.5 million, all non-competitive clinical contracts valued at over \$500,000, and all organ transplant contracts.¹⁸ All Medical Sharing Office reviews are

¹⁷VHA is the VA entity responsible for overseeing VA's health care operations.

¹⁸The Medical Sharing Office does not review any contracts for nursing services. Nursing contracts are processed and reviewed by another contracting entity in VA.

conducted before a solicitation is issued to ensure that all the necessary provisions are in place prior to any competition or award.

Procurement Operations Office. The Procurement Operations Office is responsible for providing ongoing guidance and monitoring of the COR population at VA. The Procurement Operations Office conducts reviews of COR files and publishes a COR newsletter.

Procurement Audit Office. The Procurement Audit Office is responsible for ensuring compliance with VA policies and procedures related to contracting. This office conducts internal compliance audits of contracts, including clinical contracts, once they are executed to ensure that all required documentation was included in the final contract and audits the activities of network contracting offices and Service Area Offices (SAO) to ensure their compliance with VA policies and regulations.

Procurement Policy Office. The Procurement Policy Office is responsible for providing guidance to VA's acquisition workforce in network contracting offices and SAOs. This office produces and updates standard operating procedures for CORs and COs.

Service Area Offices. SAOs are the regional contract management entities created to oversee the activities of the 21 network contracting offices and the COs and supervisors that work within them. VHA created three SAOs—East, West, and Central—to manage the contracting activities of six to eight VISNs each. SAOs review solicitations for most clinical contracts during their initial stages to ensure that all necessary provisions are in place prior to any competition or award.

Significant Weaknesses Exist in VA's Monitoring and Oversight of Non-VA Medical Care

VA Lacks Critical Data on Wait Times and Cost-Effectiveness of Non-VA Medical Care

As our recent work has found, critical data limitations related to the wait times veterans face in obtaining care from non-VA providers and the cost-effectiveness of such services hinder VA's efforts to oversee the Non-VA Medical Care Program in an effective manner.

VA does not collect data on how long veterans must wait to be seen by non-VA providers. We previously found that the amount of time veterans wait for appointments in VA facilities influenced VA's utilization of non-VA medical care. For example, in our May 2013 report, VA officials from all six facilities we reviewed reported that they routinely referred veterans to non-VA providers to help ensure that veterans receive timely care and their facilities meet performance goals for wait times for VA facility-based care.¹⁹ Officials from one of these VA facilities explained that veterans needing treatment in several specialties—including audiology, cardiology, and ophthalmology—were referred to non-VA providers for this reason.

In fiscal year 2012, VA performance goals for wait times for care in VA facilities called for veterans' primary care appointments to be completed within 7 days of their desired appointment date and veterans' specialty care appointments to be scheduled within 14 days of their desired appointment date. However, since VA did not track wait times for non-VA providers, we found that little was known about how often veterans' wait times for non-VA medical care appointments exceeded VA facility-based appointment wait time goals. Officials from one VA facility we reviewed explained that non-VA providers in their community also faced capacity limitations and may not be able to schedule appointments for veterans any sooner than the VA facility.

¹⁹See [GAO-13-441](#). These six facilities were located in Durham and Salisbury, NC; Alexandria, LA; Biloxi, MS; Las Vegas, NV; and Loma Linda, CA.

We recommended in May 2013 that VA analyze the amount of time veterans wait to see non-VA providers and apply the same wait time goals to non-VA medical care that have been used to assess VA facility-based wait times. VA concurred with this recommendation and detailed its plan to create a national consolidated monthly wait time indicator to measure performance for non-VA medical care referrals. In February 2015, VA reported that this monthly indicator had been developed and rolled out as a part of the Non-VA medical care coordination initiative. This monthly indicator tracks the number of veterans whose appointments with a non-VA provider are scheduled within 90 days—including generating the veterans' authorization to receive the care, scheduling the appointment with the non-VA provider, and receiving the veterans' medical records from the non-VA provider after the appointment is held. However, this indicator only partially implements our recommendation because it does not use the same wait time measures for non-VA medical care as are used for VA facility-based care.

VA Cannot Analyze the Cost-Effectiveness of Non-VA Medical Care

Our recent work found that limitations in the way VA collects non-VA medical care data did not allow the Department to analyze the cost-effectiveness of non-VA medical care provided to veterans. As we reported in May 2013, we found that VA lacked a data system to group medical care delivered by non-VA providers by episode of care—a combined total of all care provided to a veteran during a single office visit or inpatient stay.²⁰ For example, we reported that during an office visit to an orthopedic surgeon for a joint replacement evaluation, an X-ray of the affected joint may be ordered, the veteran may be given a blood test, and the veteran may receive a physical evaluation from the orthopedic surgeon. The non-VA provider would submit a claim to VA for the office visit and the radiologist that X-rayed the affected joint and the lab that performed the veteran's blood test would submit separate claims. However, VA's non-VA medical care data system was not able to link the charges for these three treatments together. We found that this left VA

²⁰In March 2013, VA officials told us that for inpatient claims they could construct a program to group inpatient ancillary claims together by linking all the records of individual services provided to veterans during a particular date range. However, this method relies on correct data entry by VISNs and VA facilities into the non-VA medical care claims processing system and on correct information furnished by non-VA providers. VA officials acknowledged that there is no way to link outpatient services together to create a record of a single outpatient episode of care.

without data for comparing the total non-VA medical care costs for various types of services with the VA facility-based alternative.

Without cost-effectiveness data, we concluded that VA is unable to efficiently compare VA and non-VA options for delivering care in areas with high utilization and spending for non-VA medical care. Two VA facilities we reviewed had undertaken such assessments of whether services should be provided through non-VA medical care or through an expansion of facility-based care, despite the limitations of current data.²¹ Officials at one facility reported that they expanded their operating room capacity to reduce their reliance on non-VA surgical services, saving an estimated \$18 million annually in non-VA medical care costs. Similarly, officials from the second facility reported that they were able to reduce their reliance on non-VA medical care by hiring additional VA staff and purchasing additional equipment to perform pulmonary function tests, an effort that reduced related non-VA medical care costs by about \$112,000 between fiscal years 2010 and 2012. We also found that the lack of non-VA medical care data available on an episode of care basis prevents VA from efficiently assessing the appropriateness of non-VA provider reimbursement. Specifically, VA officials cannot conduct retrospective reviews of VA facilities' claims to determine if the appropriate rate was applied for the care provided by non-VA providers.

We recommended in May 2013 that VA establish a mechanism for analyzing the episode of care costs for non-VA medical care. VA concurred with this recommendation and noted that the Department agrees that analyzing episode of care costs is an important part of its non-VA medical care monitoring activities. In February 2015, VA reported that a mechanism to analyze non-VA medical care costs on an episode of care basis would not be instituted until a planned redesign of the Department's non-VA medical care data systems is completed in fiscal year 2016. As a result, this recommendation remains unimplemented.

²¹Both these facilities conducted these analyses as part of efforts to reduce their reliance on non-VA medical care. Such decisions require careful analysis of the benefits and costs of the expansion of VA facility-based services. Before a VA facility expands its capacity, VA requires the facility to develop a business case for the expansion as part of VA's annual consideration of capital investments. These business cases must address several elements—including a financial analysis and safety issues. See Department of Veterans Affairs, *Strategic Capital Investment Planning Process*, VA Handbook 0011 (Aug. 8, 2011).

VA Lacks Automated Processes for Monitoring Non-VA Medical Care Claims Processing and Has Limited Oversight Mechanisms for Validating VA Facility Actions

Our recent reports have found that crucial limitations exist in VA's monitoring and oversight of non-VA medical care claims processing. Specifically, VA does not have automated systems to help VA facility-based claims processing staff determine whether a non-VA medical care claim is eligible for payment or notifying veterans that their claims have been denied.²² In addition, VA's oversight mechanisms—including field assistance visits to VA facilities processing non-VA medical care claims and audits of VA facilities' claims determinations—are limited due to weaknesses in their execution.

As we reported in March 2014, we found that there were no automated processes for determining whether a claim for non-VA medical care meets criteria for payment or ensuring that veterans are notified when a claim is denied.²³ Instead these processes rely largely on the judgment and diligence of VA facility-based claims processing staff reviewing each claim and their adherence to VA policies. We found that there were a number of steps in the claims review process that were susceptible to errors that could lead to inappropriate denials of non-VA medical care claims. For example, we found nine instances where a veteran's claim was denied under VA's emergency care authority for non-service connected conditions, but should have been paid under VA's preauthorized non-VA medical care authority because a VA clinician had

²²In November 2014, VA completed an organizational realignment and reassigned all VA VISN- and facility-based claims processing staff to VA Central Office. However, VA Central Office has not centralized the location of these staff and they continue to work within the VISNs and VA facilities to which they previously reported.

²³See [GAO-14-175](#). We examined a sample of 128 emergency care claims for veterans' non-service connected conditions that had been denied by VA facility claims processing staff at four VA facilities in fiscal year 2012. For our March 2014 report, we visited VA facilities in Dallas, TX; Washington, DC; White River Junction, VT; and Fort Meade, SD. We found 66 instances of noncompliance with VA policy requirements, determined that about 20 percent of the claims we examined had been denied inappropriately, and found that almost 65 percent of the claims we examined lacked documentation showing that the veteran was notified that their claim was denied. As a result of our review, the four VA facilities we visited reconsidered and paid 25 claims that they had previously inappropriately denied.

referred the veteran to the non-VA provider.²⁴ We found that in eight of these nine cases, VA facility-based personnel failed to complete critical steps in the non-VA medical care authorization process that impacted the information available to claims processing staff later in the process and without an automated process to prompt these claims processing staff to check for additional information, these claims were inappropriately denied.

In addition, according to VA policy, the Department must notify veterans in writing about denied claims and their appeal rights. However, as we reported in March 2014, we found that one VA facility we visited could not produce documentation of veteran notification for any of the 30 denied claims we reviewed. We concluded that when veterans are not informed that their claims for non-VA medical care have been denied and VA has inappropriately denied the claims, veterans could become financially liable for care that VA should have covered. Under such circumstances, veterans' credit ratings may be negatively affected and they may face personal financial hardships if they are unable to pay the bills they receive from non-VA providers. Taken together, the absence of systematic processes for completing these actions significantly reduces the assurance VA Central Office has that VA facility-based claims processing staff can consistently make accurate determinations about whether or not to pay non-VA medical care claims and notify veterans of their appeal rights in the case of denials.

In March 2014, we made six recommendations aimed at improving VA's processing of non-VA medical care claims, specifically emergency care claims for conditions not related to veterans' service-connected disabilities. These recommendations directed the Department to establish or clarify its policies and take other actions to improve VA facilities' compliance with existing policy requirements. VA concurred with these six recommendations. Based on updates we have received on VA's implementation of these recommendations, we believe VA has fully

²⁴In eight of these nine instances, VA clinicians did not properly document their referrals in VA's electronic medical record, as required by VA policy. As a result, non-VA medical care unit staff were not alerted to create authorizations for this care in the non-VA medical care claims processing system, which is a necessary step for the payment of preauthorized non-VA medical care claims. In the remaining instance, staff who processed the claim did not have access to any authorizations in the non-VA medical care claims processing system that had been issued by other VA facilities and did not know that a VA clinician from a different VA facility had referred the veteran to the non-VA provider.

implemented two of the six recommendations related to properly dating incoming claims and verifying that claims are submitted to the correct VA facility. However, we believe that for the remaining four of these recommendations, additional steps are needed to revise VA policies on claims processing roles and responsibilities. These unimplemented recommendations are related to VA's non-VA medical care policies and procedures for processing claims and notifying veterans when claims are denied.

One of VA's primary methods for monitoring its facilities' compliance with non-VA medical care claims processing requirements is field assistance visits. As we reported in March 2014, we found a number of limitations in their use as an oversight mechanism. First, we found that VA's criteria for selecting facilities for field assistance visits may not direct VA to those facilities most in need of this oversight because VA does not take into account the accuracy of claims processing activity when selecting facilities for review. Instead, we found that VA selected the 30 VA facilities that received a field assistance visit in fiscal year 2013 based on their claims processing timeliness.²⁵ With a limited focus on the timeliness of claims processing and without attention to the accuracy of claims decisions, we concluded that VA Central Office does not have the opportunity to assist VA facilities in making accurate decisions that may impact veterans financial well-being. Second, we found that the checklist VA uses for its field assistance visits does not examine all practices that could lead VA facilities to inappropriately deny claims. For example, VA's checklist does not examine VA facilities' practices for determining whether veterans are enrolled at a different VA facility and whether they have been seen by providers at another VA facility in the last 24 months—a critical criterion for determining whether veterans are eligible for emergency care coverage for non-service connected conditions. Finally, we found that VA does not hold facilities accountable for correcting deficiencies identified during these visits, and it does not validate facilities' self-reported corrections to deficiencies identified during these visits. Specifically, in our review of fiscal year 2012 and 2013 field assistance visit data, we found that some VA facilities had unresolved

²⁵In fiscal year 2013, there were 140 VA facilities that processed non-VA medical care claims.

problems in their fiscal year 2013 field assistance visit that had originated and were identified during their fiscal year 2012 field assistance visit.²⁶

In March 2014, we made two recommendations aimed at revising the scope of field assistance visits and ensuring that deficiencies identified during these visits are corrected. VA concurred with both of these recommendations. VA has made some progress in implementing these recommendations as of May 2015 by expanding the topics covered during field assistance visits and updating their standard operating procedures. However, we believe that VA needs to undertake additional actions to sufficiently address them. Specifically, VA needs to ensure field assistance visits include a review of a sample of processed claims in order to determine whether staff are complying with claims processing requirements.

Our recent work has also found that VA has no systematic process for auditing claims to ensure that they were appropriately approved or denied. VA officials stated that they recommend, but do not require, that managers of VA facility-based non-VA medical care claims processing units audit samples of processed claims—including both approved and denied claims—to determine whether staff processed claims appropriately. However, in March 2014 we found that VA did not know how many VA facilities conducted such audits and none of the four VA facilities we visited reported conducting them.

Therefore, in March 2014, we recommended that VA institute systematic audits of the appropriateness of claims processing decisions. VA concurred with this recommendation and has made some progress implementing it as of May 2015 by instituting audits of some paid claims. However, we believe that to fully implement this recommendation, VA needs to undertake additional action. Specifically, VA needs to establish systematic audits of claims processing decisions—including both approvals and denials—made by VA facility-based claims processing staff.

²⁶For example, when we reviewed these data, we found that one VA facility had been cited in fiscal year 2012 because it was not entering authorizations for referrals to non-VA providers in a timely fashion into VA's non-VA medical care claims processing system—a practice that could lead to the inappropriate denial of claims. We noted in our review of fiscal year 2013 field assistance visit data for this facility that this same deficiency had been observed again that year, even though facility officials had reported after the previous year's visit that the problem had been resolved.

Significant Limitations Exist in VA's Monitoring and Oversight of Clinical Contracts and Contractors

Contract Monitoring Is Limited by Heavy COR Workloads and Inadequate Training

As we reported in October 2013, we found that CORs cited two challenges that may compromise VA's monitoring of contractors' performance—the heavy workload associated with the COR position and the lack of adequate training for CORs.

Relating to workload, CORs at the four VA facilities we visited for our 2013 review consistently reported facing significant challenges in effectively carrying out their COR responsibilities for monitoring clinical contractors.²⁷ One challenge cited by the majority of CORs we met with (37 of 40 that completed our data collection instrument) was the assignment of the COR role as a collateral duty.²⁸ Many of these CORs' primary positions require them to manage staff, maintain budgets, and oversee other clinical providers. We found that the average COR spends about one-quarter of his or her time monitoring approximately 12 contracts, according to estimates provided by the CORs; however, some of these CORs were responsible for overseeing significantly more contracts. For example, we found that 6 of these 40 CORs managed nearly 190 of the 452 (41 percent) contracts in place at the four VA facilities we reviewed and told us they estimated spending at most 30 percent of their work time on their COR duties. In addition, we found that the CORs responsible for managing the 12 contracts we reviewed in depth frequently did not have the time to effectively monitor the performance of contract providers. Specifically, CORs for 8 of the 12 contracts reported that the demands of their primary positions had at times prevented them from fully monitoring contract providers'

²⁷For our October 2013 review, we visited VA facilities in Lebanon, PA; Minneapolis, MN; Nashville, TN; and Seattle, WA.

²⁸We administered this data collection instrument to all CORs with responsibility for clinical contracts at the four VA facilities we visited.

performance. In addition, CORs for 6 of these 12 contracts stated that they could not complete certain elements of their COR responsibilities—such as adequately monitoring contract costs—due to limited time and resources.

VA guidance requires VA facilities to provide CORs with the time to complete their responsibilities and ensure that contract compliance is managed by a knowledgeable COR. Specifically, VA's standard operating procedure for CORs requires VA facilities to provide CORs with the time and resources necessary to complete required training and fulfill their duties as a COR.²⁹ In addition, to monitor clinical contracts effectively, CORs are required to perform a number of key functions—including completing quarterly reports on contract progress, quality assurance, and invoice audits. However, we found that VA's guidance related to COR responsibilities did not include any information on how VA facilities are to determine the feasibility of whether a COR's workload—including both COR and primary position responsibilities—will allow them to carry out their tasks as CORs for monitoring contract provider performance. The COR standard operating procedure also did not provide any guidance for determining when COR duties should be assigned as a collateral duty or a full-time responsibility. We concluded that without clear guidance on how to determine a COR's workload, VA facilities can unintentionally assign COR duties to a staff member who does not have the time available to properly monitor clinical contractors. If CORs' workloads prevent proper monitoring of clinical contracts, VA risks missing the opportunity to proactively identify and correct performance issues with contract providers and to recognize patient safety concerns potentially resulting from contract providers' actions. By failing to identify performance concerns with contract providers, VA could unknowingly be receiving sub-standard service from these contractors, continue to receive services from these contract providers that do not meet the needs of the VA facilities, and risk patient safety problems when these contracts are extended for additional years.

In October 2013, we recommended that VA revise its standard operating procedures for CORs to provide guidance on the number of contracts,

²⁹See Veterans Health Administration, *Standard Operating Procedure: Contracting Officer Technical Representative*, (May 20, 2011). See also Department of Veterans Affairs Directive 1663, *Health Care Resources Contracting – Buying Title 38 U.S.C. 8153*, (Aug. 10, 2006).

based on size and complexity, each COR should manage to ensure that all CORs maintain a workload that allows them to fulfill their duties as a COR and their primary position responsibilities. VA concurred with this recommendation and detailed plans to revise existing COR standard operating procedures to include guidance on the number of contracts, based on size and complexity, that each COR should manage to ensure that all CORs maintain a workload that allows them to fulfill their duties as a COR and their primary position responsibilities. However, in April 2015, VA Central Office officials informed us that the Department no longer plans to revise these standard operating procedures in this manner, and plans instead to place language in the COR nomination letter that states that the COR and their supervisor discussed their workload and determined they could effectively serve as the COR for the contract. We believe that to fully implement our recommendation, VA needs to provide guidance to CORs and their supervisors through a revision to the COR standard operating procedures that provides guidance on the number and type of contracts each COR should manage to ensure that VA facilities and CORs can better make these determinations.

Relating to training, CORs from the four VA facilities we visited noted weaknesses in VA's COR training courses and our own analysis of these courses confirmed these limitations.³⁰ Specifically, over half of the 40 CORs from the four VA facilities we visited for our October 2013 review responded that either their COR training did not prepare them for their role as a COR or were neutral on whether or not this training was helpful preparation. In addition, CORs for 8 of the 12 contracts we reviewed in depth did not find the required COR training helpful or applicable to VA clinical contracting. For example, one COR stated that the training covered very broad areas of contracts and did not include specific information on which kinds of contracts need detailed quality assurance plans or information on how to manage a clinical contract rather than a supply contract. In addition, a few CORs stated that the instructors for their training courses had limited knowledge of clinical contracting.

³⁰VA requires CORs to complete training courses to obtain the Federal Acquisition Certification (FAC) for CORs or FAC-COR. There are three levels of FAC-COR certifications, which directly correlate with the years of a COR's contracting experience. Specifically, the FAC-COR Level I certification is an 8-hour training and does not require previous experience as a COR, the FAC-COR Level II certification is 40 hours of training (Level I combined with an additional 32 hours of training) and requires 1 year of previous experience serving as a COR, and the FAC-COR Level III certification is 60 hours of training and requires 2 years of previous experience serving as a COR.

We also reviewed the content of VA's 32-hour COR training course administered by the VA Acquisition Academy and found that this course had several limitations in preparing CORs to manage clinical contracts in VA facilities, including the following:³¹

- **Focused on contracts that buy goods, not services.** The primary examples used in the course did not include a discussion of clinical contracts at VA and instead walked students through the contracting process using examples such as replacing carpet and making a large computer equipment purchase. There were no examples focused on how to evaluate or measure the quality of services provided by a contract provider in a VA facility's clinical setting.
- **Included little information on monitoring responsibilities.** The course content included limited information for CORs on post-award monitoring responsibilities for clinical contracts and instead was heavily weighted to discussing the pre-award development of a contract.

To supplement this required course, VA's Medical Sharing Office in June 2013 developed and implemented an 8-hour training course for CORs managing clinical contracts. However, VA did not require this course be completed by all CORs managing clinical contracts.³² This course covered primarily pre-award contract development responsibilities of CORs and did not include any significant information on the post-award monitoring responsibilities of CORs managing clinical contracts.

In October 2013, we recommended that VA modify its COR training to ensure it includes examples and discussion of how to develop and monitor service contracts—including contracts for the provision of clinical care in VA facilities. VA concurred with this recommendation. In August 2014, VA provided us with a copy of its revised training modules for

³¹See GAO, *Human Capital: A Guide for Assessing Strategic Training and Development Efforts in the Federal Government*, [GAO-04-546G](#) (Washington, D.C.: March 2004). We found that well-designed training and development programs are linked to both agency goals and to the organizational, occupational, and individual skills and competencies needed for the agency to perform effectively.

³²In June 2013, the Chief of the Medical Sharing Office reported that VA had developed a proposal that makes this training course a requirement for all CORs of clinical contracts and submitted it to the Department's labor relations partners for approval. However, there is no target date for completing this review and instituting this requirement.

CORs and notified us the Department intends to require this training for all CORs.

VA's Oversight of VA Facility Clinical Contract Monitoring Is Limited

Our recent work has also found that VA has not established a robust method for overseeing the monitoring of clinical contractors by COs and CORs throughout its health care system. Our October 2013 report found that VA's primary oversight entity for health care contracting activities, the VHA Procurement and Logistics Office, has a limited role in overseeing the monitoring actions of COs and CORs once a contract has been approved and initiated at a VA facility. The VHA Procurement and Logistics Office conducts limited oversight of contracting activities throughout the VA health care system through its SAOs and Procurement Operations Office.³³

- **Service Area Offices.** According to officials from the three SAOs we interviewed for our October 2013 report, the role of the three SAOs in clinical contract monitoring is limited to an audit of the records COs maintain in VA's electronic Contract Management System. These reviews focus only on the completeness of COs' electronic contracting files—including documentation that a COR with current training records was assigned to the contract. SAO electronic Contract Management System audits did not include any reviews of CORs' monitoring of clinical contractors.
- **Procurement Operations Office.** The VHA Procurement and Logistics Office's Procurement Operations Office is the only entity responsible for overseeing the monitoring activities of CORs; however, the reviews conducted by this office were limited to a remote electronic documentation review of a small sample of COR files.³⁴ Prior to the release of our October 2013 report, officials from the

³³In June 2013, officials from the Medical Sharing Office reported that they are beginning to assess whether they can provide oversight to the post-award monitoring of COs and CORs; however, these officials noted that they did not have the necessary staff support to conduct post-award oversight. See GAO, *Internal Control: Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Standards for internal control in the federal government state that agencies should design internal controls that assure ongoing monitoring occurs in the course of normal operations, is continually performed, and is ingrained in agency operations.

³⁴Because COR files are not maintained in VA's electronic Contract Management System, the CORs for the contracts selected to be part of these reviews must send copies of their files by email to the Procurement Operations Office staff member conducting the review.

Procurement Operations Office told us that to select COR files for these reviews, a Procurement Operations Office staff member aims to select 25 COR files for active contracts per network contracting office—about 2.1 percent of clinical contracts in an average VISN if all 25 selected COR files are for clinical contracts.³⁵ VA officials told us that, while the Procurement Operations Office sets a goal to review COR files from two network contracting offices each month, since implementing the program in March 2013 these reviews had been completed in only four network contracting offices and none of these four offices had received feedback on the outcomes of these reviews as of August 2013. These reviews also had a narrow focus on the completeness of COR files because the Procurement Operations Office staff member reviewing the files relies on a checklist to verify the presence or absence of required documentation of COR monitoring activities and does not review the quality of information contained within a COR's records.³⁶

We concluded that the limited review schedule and narrow focus on file completeness did not allow the Procurement Operations Office to comprehensively assess the monitoring activities of COs and CORs throughout VA's health care system. Without a robust monitoring system in place, VA cannot be reasonably assured that all CORs in all VA facilities are monitoring clinical contractors and maintaining the proper records of their efforts to monitor the activities of clinical contractors caring for veterans.

We recommended in October 2013 that VA increase its oversight of COs and CORs by ensuring that post-award contracting files are regularly reviewed for all network contracting offices. VA concurred with this recommendation and noted that the Department would revise COR

³⁵Officials from the Procurement Operations Office told us that the actual number of files being reviewed has been typically around 21. COR files selected for these electronic documentation reviews may be for any active contract over \$250,000 that originates in the network contracting office subject to the review. These contracts can include clinical contracts, supply contracts, construction contracts, and any other type of active contract.

³⁶The file reviews assess the presence of documentation in seven key areas: (1) COR training and delegation; (2) the contract and any modifications made to the contract; (3) records of inspections they have completed and any actions taken as a result of these inspections; (4) records of technical and financial reports—including copies of invoices and purchase orders; (5) copies of all required annual contractor performance reviews and security documents; (6) copies of all communications with the contractor and CO; and (7) verification that all contract providers have completed required VHA training.

standard operating procedures to ensure that regular reviews of post-award contract files from all network contracting offices are conducted. While VA has made progress in implementing this recommendation by completing 45 more reviews of COR files in fiscal year 2014 than in fiscal year 2013, these reviews were still only conducted in 5 of the 21 network contracting offices. We believe that to fully implement this recommendation VA needs to ensure that a sample of COR files are reviewed from all network contracting offices.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this statement, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this statement include Marcia A. Mann, Assistant Director; Jackie Hamilton; Katherine Nicole Laubacher; and Emily Ryan.

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