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The Office of Integrated Veteran Care Needs to Improve Community Dialysis Oversight and Develop a Strategy to Align Future Contracts with the MISSION Act

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Executive Summary

Veterans with end-stage renal disease are often prescribed dialysis, a lifesaving medical procedure that removes excess fluids and toxins from the bloodstream. Veterans may receive dialysis services from Veterans Health Administration (VHA) medical facilities and Department of Defense facilities with a sharing agreement, or may be referred by a VHA medical facility dialysis coordinator to a non-VA medical provider in the community.[1] About 81 percent of veterans who received dialysis treatment from VHA in fiscal years 2021 and 2022 (about 21,000 of 25,900) did so from community providers in their first episode of dialysis treatment. The Office of Integrated Veteran Care (IVC) is responsible for managing the delivery of community dialysis services through nationwide dialysis services contracts (NDSCs) and community care network (CCN) contracts. The CCN is made up of five regional networks that VHA uses to purchase care for veterans from community providers. In limited situations, when the CCN cannot meet veteran demand, dialysis services are also provided through veterans care agreements (VCAs).[2] VCAs are agreements with community providers while they transition to the CCN. In addition, VHA medical facilities can use local contracts when needed care is not otherwise available.[3]

VHA awarded 18 NDSCs in 2019, with options to extend the contracts up to five years. While NDSCs help provide veterans with access to a network of dialysis providers throughout the United States, VHA pays NDSC providers a higher rate than CCN providers. In 2020, VA was able to transition nine NDSCs to the CCN and instructed VHA medical facility dialysis coordinators to refer veterans to NDSCs only if VHA and CCN providers are unavailable.[4] VHA relies heavily on community providers for dialysis services and spent about $1.2 billion on these services from October 2020 through September 2022. Therefore, the Office of Inspector General (OIG) conducted this audit to determine if VHA effectively provides veterans access to dialysis

[1] The team did not identify any encounters at the three joint VA and Department of Defense dialysis sites identified by VHA during the period reviewed.

[2] VHA Office of Community Care, *Field Guidebook*, Specialty Programs, "Dialysis," October 2, 2020. This guidebook was in place during the time of events discussed in this report. It was last updated by VHA IVC, *Community Care Field Guidebook*, Specialty Programs, "Dialysis," September 30, 2022. Unless otherwise specified, the 2022 guidebook contains the same or similar language regarding dialysis as the 2020 guidebook. In addition, the option to refer a veteran to a Department of Defense facility with a sharing agreement was added during the audit period.

[3] VA deputy under secretary for health for operations and management, "Community Care Purchasing Authorities," memorandum to Veterans Integrated Service Network directors, December 20, 2018.

[4] Office of Community Care, "Dialysis National Contract–June 2020 Meeting," July 2020; Office of Community Care, "Dialysis National Contract Call–July 30th, 2020," July 2020. The community dialysis referral process is detailed in the *Community Care Field Guidebook*.

services by evaluating whether it followed its prescribed referral process, which prioritizes the use of available CCN over NDSC providers.

According to the contracts, payments to NDSC and CCN providers are based on a percentage of the Medicare rate. VA also pays the Medicare rate for care provided through VCAs and local contracts.[5] Annually, the Centers for Medicare and Medicaid Services (CMS) publicizes bundled rates for dialysis services treating end-stage renal disease. The payment for each dialysis treatment is intended to cover all operating and capital costs that providers would incur. The rate for a dialysis claim may also include a patient- and provider-level adjusted, per-treatment payment.[6] CMS also considers updates to these rates for wages, drugs, laboratory services, supplies, and other costs related to providing dialysis.[7] VA pays CCN providers up to the Medicare rate and also pays for some administrative fees for dialysis services, which are based on a per veteran, per month rate. The Medicare rate was about $253 for 2021 and almost $258 for 2022.[8]

In contrast, VA pays NDSC providers an adjusted amount for a veteran equal to 100 percent of the Medicare rate for dialysis services multiplied by the negotiated contracted rate. The NDSC rates range from [redacted] to [redacted] percent of the Medicare rate, which could be as much as [redacted] more per treatment.[9] The audit team verified that, in some locations, NDSC providers that serve veterans also perform dialysis for Medicare patients at lower rates.

According to the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, community provider reimbursement cannot exceed Medicare rates unless certain exceptions apply.[10] These exceptions include dialysis services in highly rural areas, Alaska, and states with

[5] For VCAs and local contracts, VA may permit different rates, when applicable.

[6] For purposes of OIG analysis, a claim represents a line item or items paid reflecting a claim identifier, social security number, date of service, procedure code, and other related fields.

[7] CMS: Medicare Program: End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model, 86 Fed. Reg. 213, 61874–62026 (Nov. 8, 2021).

[8] CMS: Medicare Program: End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 85 Fed. Reg. 217, 71398-71487 (Nov. 9, 2020); CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 86 Fed. Reg. at 213, 61874–62026.

[9] The OIG redacted contracted rate information for the NDSCs from this report at VA's request under the Freedom of Information Act, 5 U.S.C. § 552, Exemption 3, applying 41 U.S.C. § 423(a).

[10] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703(i).

an all-payer model.[11] An exception may be made when VA determines, based on patient needs, market analyses, healthcare provider qualifications, or other factors, that it is not practicable to limit payment for services to the Medicare rates.[12] Although the MISSION Act was not in effect at the time the NDSCs were awarded in April 2019, VA must consider these requirements in future contracts.[13] At that time, VHA announced its intent to transition dialysis services from the NDSCs to the CCN as a way to lessen its reliance on NDSCs and increase its use of the CCN for services. Because the NDSCs will expire at the end of September 2024, VA must either work to transfer services to CCN providers or take immediate steps to make sure rates negotiated for subsequent dialysis contracts are at or below the Medicare rate to the extent practicable.

What the Audit Found

VHA experienced several barriers to ensuring compliance with its community dialysis referral requirements and increasing use of CCN providers over NDSC providers. Specifically, IVC did not effectively oversee dialysis care in the community. IVC did not clearly assign oversight responsibilities for community dialysis services, ensure medical facility dialysis coordinators followed required referral steps, or use available data to inform decisions. To assess whether VHA effectively provides veterans access to community dialysis services, the audit team used multiple sources of information, including applicable federal regulations and standards, VA policies and procedures, acquisition regulations, and guidance applicable to the contracts. Further, the team conducted a survey of medical facility dialysis coordinators and interviewed VHA personnel.[14]

[11] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703(i). VA considers highly rural areas to be sparsely populated areas with less than 10 percent of the working population commuting to any community larger than an urbanized cluster, which is typically a town of no more than 2,500 people. "Rural Veterans" (web page), Office of Rural Health, accessed October 10, 2023, https://www.ruralhealth.va.gov/aboutus/ruralvets.asp#:~:text=Rural%20Area%3A%20Land%20areas%20not,no%20more%20than%202%2C500%20people. G. Kominski and T. Rice, "Should insurers pay the same fees under an all-payer system?" *Health Care Financing Rev.* 16(2) (Winter 1994): 175–89, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193492/. Under an all-payer model, providers in a state use the same payment methods and rates. No patient would be worth any more to a provider than any other. States can apply for a waiver from CMS to become an all-payer state. According to CMS, Maryland, Vermont, and Pennsylvania have all-payer models.

[12] 38 C.F.R. § 17.4035 (2022); CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 85 Fed. Reg. at 217, 71398–71487; CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 86 Fed. Reg. at 213, 61874–62026.

[13] 38 C.F.R. Part 17 (2019). The MISSION Act was signed into law in June 2018 and § 1703 of the Act was effective in June 2019.

[14] Appendix A provides additional information on the audit's scope and methodology.

Establishing an organizational structure, assigning responsibility, and delegating authority are actions that leaders need to take to drive change.[15] However, IVC did not assign oversight responsibility for community care dialysis referral activities that occur at the medical facility level. Without assigned roles and responsibilities, facility dialysis coordinators were not always aware of proper program procedures. Further, IVC did not develop processes to monitor whether veterans were consistently referred to CCN dialysis providers first when available. The audit team found that some facility dialysis coordinators did not follow the required steps when referring veterans to community care, and that IVC's guidance did not indicate when local contracts should be used. While IVC's guidance also did not specifically address veteran preference during the referral process, coordinators reported taking it into consideration. The team also found some inaccurate or incomplete data in the information system used by dialysis coordinators to identify available providers.

While reviewing the rates for dialysis options available to veterans in the community, the audit team identified geographic areas where providers charged different rates for similar services. IVC does not monitor the geographic areas where dialysis services are offered by both NDSC and CCN providers or analyze the different rates among providers in the same areas. IVC should leverage available community dialysis care capacity to support the full transition to the CCN and meet MISSION Act payment rate requirements. While some IVC officials reported to the team that IVC intended to transition from NDSC to CCN providers for dialysis services, they were not involved in developing or executing a strategy to realize this goal. By engaging stakeholders involved with community dialysis services, VHA can better inform its future community-based dialysis care contracts and facilitate the transition from NDSC to CCN providers, especially in areas where both are readily available.

Strengthening oversight and analyzing readily available data on community dialysis services would improve IVC's ability to transition dialysis providers to the CCN while ensuring MISSION Act payment rate compliance. Further, given that NDSC providers charge at least [redacted] percent over the Medicare rate for dialysis, taking steps to continue to transition veterans to the CCN could result in cost savings to VA. IVC's efforts should include steps to mitigate the impact to veterans already receiving these services.[16]

[15] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-70G, September 2014.

[16] On August 18, 2023, IVC submitted a charter for an integrated project team responsible for developing a strategy for awarding future NDSCs, as the current NDSCs are expiring in September 2024. The draft date of the charter was August 15, 2023. The OIG does not have an opinion on this charter as it was provided after the audit work was conducted.

What the OIG Recommended

The OIG recommended that the under secretary for health clarify guidance on local dialysis contract options and when they should be used, establish roles and responsibilities to ensure dialysis coordinators follow required procedures when referring veterans to dialysis care in the community, and develop and implement a plan to regularly examine and validate dialysis provider data for accuracy and completeness in the information system used by dialysis coordinators. The OIG also recommended that VHA develop and implement a strategy to ensure that any new dialysis service contracts follow MISSION Act payment rate requirements.

VA Management Comments and OIG Response

VHA's under secretary for health concurred with all four recommendations and submitted an acceptable corrective action plan with an anticipated completion date of December 2023. IVC will ensure that its guidance includes when local dialysis contract options can be used, and defines the roles and responsibilities of VHA facility personnel involved in coordinating community dialysis services. Further, IVC will establish a team to perform periodic reviews of dialysis provider information and other work to improve data quality. Finally, VA will research strategies regarding market-specific analysis and service utilization in both VA and community care and determine veterans' needs by location to inform potential market rate determination. Appendix B provides the full text of the under secretary's comments. The OIG will monitor implementation of the planned actions and will close the recommendations when VA provides documentation demonstrating sufficient progress in addressing the issues identified.

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Contents

Abbreviations

CCN	community care network
CMS	Centers for Medicare and Medicaid Services
GAO	Government Accountability Office
IVC	Office of Integrated Veteran Care
MISSION Act	The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act
NDSC	nationwide dialysis services contract
OIG	Office of Inspector General
PPMS	Provider Profile Management System
VCA	veterans care agreement
VHA	Veterans Health Administration

Introduction

End-stage renal disease is considered a chronic condition unless a kidney transplant is performed. Veterans with end-stage renal disease are often prescribed dialysis—a lifesaving medical procedure that uses a machine to remove excess fluids and toxins from the bloodstream—typically three days a week. Veterans may receive dialysis from Veterans Health Administration (VHA) medical facilities and Department of Defense facilities with a sharing agreement, or facility dialysis coordinators can refer them to non-VA medical providers in the community.[17] Care is provided in the community for various reasons, including because the VHA medical facility does not have the capacity to provide the care or is located too far from the veteran's home (typically longer than a 60-minute drive for specialty care).[18] About 81 percent of veterans who received dialysis treatment in fiscal years 2021 and 2022 did so in the community.[19]

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 allows veterans, when eligible, to choose to use community providers even if a VA provider is available.[20] To implement expanded access to care, VA contracts with third-party administrators to use their network of community providers for veteran care. Dialysis services in the community are generally provided through nationwide dialysis services contracts (NDSCs) or community care network (CCN) contracts.[21] VHA's Office of Integrated Veteran Care (IVC) is responsible for managing delivery of dialysis services through NDSCs and the CCN.[22] According to VHA guidance, when the CCN cannot meet veteran demand, dialysis may also be provided through

[17] VHA Office of Community Care, *Field Guidebook*, Specialty Programs, "Dialysis," October 2, 2020. This guidebook was in place during the time of events discussed in this report. It was last updated by VHA IVC, *Community Care Field Guidebook*, Specialty Programs, "Dialysis," September 30, 2022. Unless otherwise specified, the 2022 guidebook contains the same or similar language regarding dialysis as the 2020 guidebook. The *Community Care Field Guidebook* does not reference dialysis and local contracts. In addition, the option to refer a veteran to a Department of Defense facility with a sharing agreement was added during the audit period. The team did not identify any encounters at the three joint VA and Department of Defense dialysis sites identified by VHA during the period reviewed.

[18] VHA Office of Community Care, "Veteran Community Care Eligibility" (fact sheet), August 30, 2019.

[19] About 21,000 of 25,900 veterans received dialysis care for end-stage renal disease from the community provider types reviewed for their first episode of dialysis treatment from October 2020 through September 2022.

[20] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703(d)(1).

[21] The CCN is made up of five regional networks that serve as the contract vehicle for VHA to purchase care for veterans from community providers.

[22] In April 2022, VHA's Office of Community Care and Office of Veterans Access to Care merged to become the VHA Office of Integrated Veteran Care. Acting under secretary for health, VHA, "Notification of Program Office Reorganization," memorandum to VHA Senior Leaders, September 23, 2021.

veterans care agreements (VCAs).[23] VCAs are intended to be used in limited situations when contracted services through the CCN are not provided or are not sufficient to ensure veterans can get the care they need. VCAs are agreements between specific medical facilities and community providers to provide authorized care at specified rates.[24] In addition, VHA medical facilities can use local contracts when needed care is not readily available.[25] However, unlike VCAs, local contracts must comply with the Federal Acquisition Regulation.

Figure 1 shows the order in which facility dialysis coordinators should refer veterans to community dialysis providers when care cannot be provided at a VHA medical facility or a Department of Defense facility and the veteran does not indicate a provider preference. Although IVC's *Community Care Field Guidebook* does not explicitly direct dialysis coordinators to consider veteran preference, coordinators informed the audit team that they do consider it. If no CCN or NDSC provider is available, a VCA can be used.[26] These instructions did not reference local contracts.

Figure 1. *Community contract referral pathway as of September 2022.*

Source: VA OIG analysis of IVC's Community Care Field Guidebook.

**Use only as a bridge while signing the provider on to a CCN contract.*

Note: Local contracts for dialysis are not referenced in IVC's Community Care Field Guidebook.

VHA awarded 18 NDSCs in 2019; each was for one year with options to extend up to five years. In April 2019, when VA awarded the NDSCs, the contracts included a statement noting that VA intended to transition dialysis services to the CCN to lessen its reliance on NDSCs. VA also included language in the terms of its NDSCs that it may choose to not exercise options to extend

[23] VCAs are authorized under 38 U.S.C. § 1703A and their use for obtaining community dialysis services is detailed in the *Community Care Field Guidebook.*

[24] VHA Office of Community Care, "Veterans Care Agreements (VCAs)" (fact sheet), September 9, 2019.

[25] VA deputy under secretary for health for operations and management, "Community Care Purchasing Authorities," memorandum to Veterans Integrated Service Network directors, December 20, 2018.

[26] Facility dialysis coordinators can refer veterans to VCA providers but should only do so if dialysis services are not available through a CCN or NDSC provider. VCAs are intended to be used in limited situations when contracted services through VHA's CCN are not provided or are not sufficient to meet veteran demand.

the period of performance for these contracts in the regions where dialysis delivery in the CCN has been achieved. VA also may modify the terms of its NDSCs to remove dialysis providers, or it may transition authorizations from these contracts to the CCN contracts.

In 2020, VA did not renew nine of its NDSCs because it was able to transition those providers to the CCN, and VHA pays CCN providers a lower rate than NDSC providers. The Office of Inspector General (OIG) conducted this audit to determine if VHA effectively provides veterans access to dialysis services by evaluating whether it followed its prescribed referral process, which prioritizes the use of available CCN over NDSC providers.

Overview of Contracted Dialysis Services Provided in the Community

From October 2020 through September 2022, NDSCs provided care to almost all veterans (about 93 percent) who get dialysis care in the community at a total cost of about $1.2 billion.[27] During this time, about 7 percent of veterans receiving dialysis care in the community did so through CCN or VCA providers. The team also determined that VHA medical facilities recorded 618,373 dialysis encounters for 6,548 veterans, which cost an estimated $553.8 million.[28] The cost for each encounter may reflect the direct and indirect costs of care associated with all medical procedures involved with the encounter. Table 1 details the number of veterans served by contracted dialysis provider type and the associated costs for fiscal years 2021 and 2022.[29]

Table 1. Cost Summary for Dialysis Services in the Community

Contracted dialysis provider type	Number of veterans in fiscal year 2021	Amount paid in fiscal year 2021 (rounded in millions)	Number of veterans in fiscal year 2022	Amount paid in fiscal year 2022 (rounded in millions)
NDSC	16,578	$606.8	16,409	$616.8
CCN	903	$21.1	866	$22.6
VCA	305	$7.0	271	$6.1
Local	12	$0.1	4	$0.1
Other*	24	$0.3	21	$0.4

[27] There are two types of dialysis—hemodialysis and peritoneal. This report and analysis focused on in-facility hemodialysis, which is referred to as "dialysis."

[28] Encounters do not directly correlate to claims. These totals are attributed to Decision Support System encounter data. The cost for each encounter may reflect the direct and indirect costs of care for up to 25 current procedural terminology codes. Direct costs can include administrative functions in a department, whereas indirect costs are allocated to overhead support, such as utilities.

[29] Claims for services provided by nephrologists, who treat kidney diseases, are not included in the audit team's cost summary.

Source: VA OIG analysis of paid community dialysis claims for fiscal years 2021 and 2022 as of December 2022. For purposes of OIG analysis, a claim represents a line item or items paid reflecting a claim identifier, social security number, date of service, procedure code, and other related fields.

Note: This table may not include all claims for dialysis services for fiscal years 2021 and 2022 because some claims may not have been processed when the data were obtained in December 2022.

**The team determined 14 dialysis providers were identified in claims data that did not match any of the NDSC, CCN, or VCA provider data using national provider identifiers and zip codes. A VHA manager familiar with network adequacy reported this may have occurred due to the necessary provider information not being in the Provider Profile Management System.*

Rates for Community Dialysis Services

In accordance with the MISSION Act, community provider reimbursement, including reimbursement for dialysis, cannot exceed Medicare rates unless certain exceptions apply.[30] These exceptions include dialysis services in highly rural areas, Alaska, and states with an all-payer model where all third parties pay the same rate.[31] An additional exception may be made when VA determines, based on patient needs, market analyses, healthcare provider qualifications, or other factors, that it is not practicable to limit payment for services to the Medicare rates.[32] Even though the MISSION Act was not in effect at the time the NDSCs were awarded in April 2019, any new community dialysis contracts, including NDSCs, must comply with the MISSION Act's requirements to only pay Medicare rates unless an exception applies.[33]

Annually, the Centers for Medicare and Medicaid Services (CMS) publicizes bundled rates for dialysis services provided for the treatment of end-stage renal disease.[34] The Medicare rate was

[30] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703(i).

[31] MISSION Act, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 1703(i). VA considers highly rural areas to be sparsely populated areas with less than 10 percent of the working population commuting to any community larger than an urbanized cluster, which is typically a town of no more than 2,500 people. "Rural Veterans" (web page), Office of Rural Health, accessed October 10, 2023, https://www.ruralhealth.va.gov/aboutus/ruralvets.asp#:~:text=Rural%20Area%3A%20Land%20areas%20not,no%20more%20than%202%2C500%20people. G. Kominski and T. Rice, "Should insurers pay the same fees under an all-payer system?" *Health Care Financing Rev.* 16(2) (Winter 1994): 175–89. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193492/. Under an all-payer model, providers in a state use the same payment methods and rates. No patient would be worth any more to a provider than any other. States can apply for a waiver from CMS to become an all-payer state. According to CMS, Maryland, Vermont, and Pennsylvania have all-payer models.

[32] 38 C.F.R. § 17.4035 (2022).

[33] 38 C.F.R. Part 17 (2019). The MISSION Act was signed into law in June 2018 and § 1703 of the Act was effective in June 2019.

[34] The rate for a dialysis claim may also include a patient and provider-level adjusted per treatment payment. CMS also considers updates to these rates for wages, drugs, laboratory services, supplies, and other costs related to providing dialysis. CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model, 86 Fed. Reg. 213, 61874-62026 (Nov. 8, 2021).

$253.13 for 2021 and $257.90 for 2022.[35] VA pays CCN providers up to the Medicare rate and also pays some administrative fees for dialysis services, which are based on a per veteran, per month rate.[36] VA also pays the Medicare rate for care provided through a VCA and local contracts.[37] VA is responsible for any payment or fee arising from care authorized through VCAs.

In contrast to the Medicare rate paid under CCN contracts, VA pays NDSC providers an adjusted amount for a veteran equal to the full Medicare rate multiplied by the negotiated contracted rate for dialysis services. The NDSC rates range from [redacted] to [redacted] percent of the Medicare rate.[38] For example, if VA pays [redacted] percent of the Medicare rate to an NDSC provider, the cost would be approximately [redacted], which is about [redacted] above the 2022 Medicare rate. VA also pays administrative fees for dialysis services that are based on a fixed cost according to the volume of claims processed.

VA exercised the option periods for its nine NDSCs, effective in October 2022, extending them through the end of September 2023, and later exercised the options to extend the contracts through September 2024.[39] VA also exercised the CCN contract options for regions 1, 2, 3, and 5, which are set to expire in September 2024. The CCN contract option for region 4 will expire in March 2024. With the upcoming end of these contracts, future contracts will be necessary to support the demand for community dialysis care. In addition, VA will need to take steps to transition these NDSC providers to the CCN or award NDSCs and other dialysis contracts with rates comparable to the Medicare rate to the extent practicable.

Entities Involved with the Delivery of VHA's Dialysis Services

Several VA and VHA offices and positions are responsible for the delivery of community dialysis services. As shown in table 2, national offices, as well as VHA medical facilities, have roles in how these services are provided to veterans. VA contracting officers who are responsible for ensuring providers comply with the terms and conditions of the CCN contracts and NDSCs

[35] CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 85 Fed. Reg. 217, 71398–71487 (Nov. 9, 2020). CMS: Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, and End-Stage Renal Disease Quality Incentive Program, 86 Fed. Reg. at 213, 61874–62026. As of January 1, 2011, CMS uses a bundled prospective payment system for renal dialysis services provided to Medicare beneficiaries for the treatment of end-stage renal disease. The base payment for each dialysis treatment is intended to cover all operating and capital costs that providers would incur.

[36] The team did not consider administrative contract costs as part of the audit because they were not comparable.

[37] For VCAs and local contracts, VA may permit different rates, when applicable.

[38] The OIG redacted contracted NDSC rate information from this report at VA's request under the Freedom of Information Act, 5 U.S.C. § 552, Exemption 3, applying 41 U.S.C. § 423(a).

[39] The rates for these contracts were consistent for the duration of each contract.

are part of VA's Strategic Acquisition Center.[40] The VA contracting officers delegated authority to perform certain contract administration duties for the NDSCs and the CCN to contracting officer's representatives in VHA's IVC.[41] At medical facilities, clinicians enter consults for dialysis services, while community care staff assist in identifying community dialysis providers. Typically, facility dialysis coordinators collaborate with community care staff to oversee the processing of these consults and authorizations. However, sometimes the facility's community care office is responsible for the referral. Regardless of who makes the referral to the community, VHA requires that veterans be referred in accordance with the process detailed in figure 1, which prioritizes CCN providers, when available, over NDSC and VCA providers. Table 2 provides an overview of the responsible offices and positions involved with the contracts.

Table 2. Entities and Roles Involved in Providing Dialysis Services to Veterans

Entity	Role
VA	
Office of Acquisition, Logistics, and Construction	Responsible for directing VA acquisition, logistics, construction, and leasing
Strategic Acquisition Center	Responsible for the NDSCs and CCN contracts
VHA	
Kidney Health Committee	Provides multidisciplinary oversight of VA kidney health services; responsible for ensuring veteran access to dialysis through VA or community arrangements
VHA National Kidney Program	Provides kidney-related services to dialysis centers throughout VHA's medical facilities, including consultation and policies developed by VA kidney experts
IVC	Manages veterans' access to care through both VA and community providers
Integrated External Networks	Requested and developed requirements for the NDSCs and CCN contracts; oversees community dialysis contractors' performance
Integrated Field Operations	Answers questions from VHA medical facility personnel on coordinating consults for contracted dialysis care and develops guidance
Medical facilities	Make decisions locally to coordinate and purchase dialysis care from community dialysis facilities

[40] FAR 1.602-2 (2019).

[41] FAR 1.602-2, 1.602-2(d), and 1.604 (2019).

Source: VA OIG analysis of VA websites, VHA Directive 1053, IVC's Community Care Field Guidebook*, Functional Organizational Manual, VA Notification of Program Office Reorganization Memorandum, and dialysis contract information.*

Relevant Community Care Guidance

In addition to the MISSION Act, the audit team considered the following documents to evaluate the delivery of community dialysis services:

- VHA Directive 1053—*Chronic Kidney Disease Prevention, Early Recognition, and Management.* This directive describes VHA's strategy for prevention, recognition, management, and evaluation of chronic kidney disease in the veteran population; responsibilities of VHA leaders; front-line staff in implementing this strategy; and resources and tools to assist in implementation of chronic kidney disease programs nationwide.[42]
- *IVC's Community Care Field Guidebook.* This guidebook, which is periodically updated, details procedures VHA medical centers must follow when veterans are referred to the community for dialysis services at VHA's expense.[43]

[42] VHA Directive 1053, *Chronic Kidney Disease Prevention, Early Recognition, and Management*, March 17, 2020.
[43] *Community Care Field Guidebook.*

Results and Recommendations

Finding: IVC Needs to Improve Its Management of Dialysis Care in the Community and Develop a Strategy to Align New Contracts with MISSION Act Requirements

In July 2020, VHA instructed medical facility dialysis coordinators to refer veterans to available CCN providers before NDSC providers.[44] However, the audit team's review identified noncompliance with this guidance. Following the referral process is significant because the MISSION Act requires VHA not to exceed Medicare rates for CCN dialysis to the extent practicable or unless a specific exception applies.[45] As a result, VHA pays CCN dialysis providers rates that are less than the rates it pays NDSC providers by as much as about [redacted] per treatment.

In 2019, VHA awarded 18 NDSCs to provide veterans with access to a network of dialysis providers, with options to extend the contracts up to five years. In 2020, VA did not renew nine of these contracts because it was able to transition those providers to the CCN. VHA extended the remaining NDSCs in 2022 for another year and reported that community-based dialysis care in the geographic areas serviced by these contracts was still needed. However, IVC did not fully assess available data on veteran demand for and use of NDSC providers compared to available CCN providers. Most veterans who received dialysis care in the community were treated by an NDSC provider in fiscal years 2021 and 2022, in part because in some locations there are fewer CCN providers. However, the audit team found from March 2020 through December 2022, the number of CCN dialysis providers increased significantly nationwide—by about 350 percent. Despite this growth, VHA did not fully leverage existing CCN capacity where it is available. For example, about 52 percent of available CCN providers were not used from October 2020 through September 2022. This occurred because IVC did not develop processes to make sure that medical facilities fully leveraged available CCN capacity for dialysis services.

The following elements support the OIG's finding:

- IVC lacks assurance that medical facility dialysis coordinators consistently refer veterans who require community dialysis services to available CCN providers first.

[44] Office of Community Care, "Dialysis National Contract–June 2020 Meeting," July 2020; Office of Community Care, "Dialysis National Contract Call–July 30th, 2020," July 2020.

[45] In 2022, the Medicare reimbursement rate for dialysis was about $258 per treatment. As previously noted, community provider reimbursement cannot exceed Medicare rates except in highly rural areas, Alaska, and states with an all-payer model. An exception may be made when VA determines, based on patient needs, market analyses, healthcare provider qualifications, or other factors, that it is not practicable to limit payment for services to the Medicare rates.

- IVC needs to make sure that dialysis coordinators have complete and accurate information on community dialysis providers.
- IVC needs to take steps to clarify oversight responsibilities for community dialysis services.
- IVC did not effectively use available data on dialysis services in the community.
- IVC did not have a strategy to support future community dialysis contracts in compliance with MISSION Act requirements.

What the OIG Did

The team interviewed IVC personnel who were involved with the management of NDSC and CCN dialysis services in the community. The team reviewed relevant NDSC and CCN documentation, assessed how VA exercised the contract options for the NDSCs, and conducted interviews with the VA contracting officer responsible for the NDSCs and the contracting officer's representatives responsible for the NDSCs and the CCN.

To evaluate if dialysis coordinators had access to accurate NDSC and CCN provider data, the audit team reviewed requirements for maintaining these data, as well as assessed the data for select community dialysis providers. In addition, the team contacted dialysis coordinators about their responses to the team survey, which, in part, included questions on how dialysis providers (CCN, NDSC, and VCA) were selected locally. Appendix A provides additional details on the audit scope and methodology.

IVC Lacks Assurance That Medical Facility Dialysis Coordinators Consistently Refer Veterans Who Require Community Dialysis Services to Available CCN Providers First

Since July 2020, medical facility dialysis coordinators have been instructed to determine if a CCN provider is available before referring the veteran to other community providers, including NDSC dialysis centers.[46] IVC, however, has little assurance that dialysis coordinators are following this process locally because it has not assigned oversight responsibilities or taken steps to develop processes to monitor compliance. In fiscal years 2021 and 2022, about 7,700 veterans began receiving dialysis care from community providers, or an average of 336 veterans per month. However, the large majority of these veterans were referred to NDSC providers, with an

[46] Office of Community Care, "Dialysis National Contract–June 2020 Meeting;" Office of Community Care, "Dialysis National Contract Call–July 30th, 2020."

average of only about 7 percent referred to the CCN.[47] These veterans are new entrants into VHA's community-based dialysis services and represent an opportunity for VHA to better leverage available CCN capacity and reduce costs.

Despite the requirement to search the CCN prior to referring veterans to NDSC providers for dialysis, only about 69 percent of dialysis coordinators who responded to the OIG's survey (97 of 141) reported that they always do so.[48] Dialysis coordinators are supposed to use either VHA's Provider Profile Management System (PPMS) or the Community Provider Locator to identify available CCN, NDSC, and VCA dialysis providers.[49] The team interviewed dialysis coordinators from eight medical facilities and learned that rather than using the required information systems, these coordinators relied on memory, self-maintained lists of local providers, and vendor-maintained websites such as https://dialysisfinder.com/ to identify providers. Several coordinators also reported veteran preference and dialysis needs are primary considerations that inform their provider selection. As a result, VHA is at risk of dialysis coordinators not fully leveraging available CCN provider capacity despite the number of CCN facilities offering dialysis services increasing by 524 facilities—from 149 to 673—between March 2020 and December 2022.[50] Consider the case of Chicago, Illinois, discussed below.

Chicago, Illinois

The audit team assessed the extent to which the eight available CCN providers were being used as compared to the four NDSC providers operating across Chicago's 58 zip codes. The team compared dialysis provider information to claims data and found that VHA did not pay any claims to the eight CCN providers who operated in seven of the Chicago zip codes between October 2020 and September 2022. Two NDSC providers operate 63 facilities over these zip codes, and VHA paid over 11,000 claims to them. Moreover, although VHA did not pay any claims to the CCN providers who operated in the pertinent zip codes, VHA did pay about 400 claims to two smaller NDSC providers who operate three facilities within the zip codes. Each of the NDSC providers is paid more than the Medicare rate.

[47] The audit team identified the number of new veterans receiving dialysis services by considering those whose earliest claim during the period reviewed was with an NDSC or CCN provider. For this analysis, the team excluded veterans who received dialysis services in October 2020 to account for veterans who may have already been receiving dialysis services prior to the beginning of the team's review period.

[48] Figure 1 details the required process that medical facility dialysis coordinators should follow when referring veterans to the community for dialysis services.

[49] PPMS is an information repository of community providers. It collects and retains information on community care healthcare providers or community care providers. In some cases, dialysis coordinators do not have direct access to PPMS. Instead, they can use the Community Provider Locator, which accesses the same provider information.

[50] The team determined the growth in CCN facilities providing dialysis services using PPMS provider data for active providers as of December 2022.

A representative at the Jesse Brown VA Medical Center in Chicago reported that the process for referring veterans to community dialysis providers uses preference first, and referrals are based on historical knowledge of where dialysis facilities are located. Table 3 details the contract rate as a percentage of the Medicare rate and the distribution of dialysis providers in Chicago that were available to veterans at some point between October 2020 and September 2022.

Table 3. Community Dialysis Providers in Chicago

Entity	Contract rate compared to the Medicare rate	Number of zip codes*	Number of contracted dialysis providers in those zip codes	Number of claims paid	Total amount paid (rounded in millions)
Contractor B (NDSC provider)	[redacted]	28	35	5,035	$1.8
Contractor E (NDSC provider)	[redacted]	21	28	6,286	$2.1
Contractor G (NDSC provider)	[redacted]	1	1	354	$0.1
Contractor H (NDSC provider)	[redacted]	2	2	60	$0.02
CCN	100%	7	8	0	$0

Source: VA OIG analysis of paid community dialysis claims during fiscal years 2021 and 2022 as of December 2022.

Note: This table may not include all claims for dialysis services for fiscal years 2021 and 2022 because some may not have been processed when the data were obtained in December 2022.

**A provider could operate in more than one zip code.*

The audit team's detailed analysis of the dialysis providers in Chicago examined the extent to which veterans received dialysis services in zip codes with both CCN and NDSC providers. In the seven zip codes that contained both CCN and NDSC providers, the team identified eight CCN facilities and nine NDSC facilities overall.[51] For two of these zip codes (60607 and 60652), each had three NDSC providers and one CCN provider. Of the six NDSC providers that operated in these zip codes, four of them had claims paid during fiscal years 2021 and 2022. Specifically, VHA paid these NDSC providers for 930 claims during this period, but there were no claims paid for the CCN providers. The team also noted there were CCN providers about a mile away from the closest NDSC provider, but the CCN providers still were not used.

Dialysis coordinators also did not revisit a veteran's placement with a community dialysis provider during the required annual reauthorization process to continue care. During the process, coordinators are required to determine several factors, including if their VHA medical facility

[51] The seven zip codes are 60607, 60631, 60643, 60652, 60657, 60686, and 60693.

has the capacity to provide the dialysis care or if any CCN providers are closer than a 60-minute drive for the veteran.[52] The audit team interviewed 10 dialysis coordinators about the reauthorization process. Of these, six were at VHA medical facilities that offered in-house dialysis care, and all six reported not contacting veterans before reauthorizing their care in the community. Decisions to reauthorize a veteran's care with an NDSC provider should take into account whether the same care is available at the facility or through a CCN provider with minimal impact to the veteran already receiving service.

The OIG does not dispute the importance of factors such as veteran preference when considering dialysis providers and is not suggesting medical facilities arbitrarily transition veterans from their existing providers. However, by not making sure veterans are informed about other available providers, VHA is missing opportunities to provide veterans with all available dialysis care options. Inadequate compliance with both the initial referral and reauthorization processes hinders IVC's stated goal of transitioning veterans from NDSC to CCN dialysis providers.

IVC Needs to Make Sure That Dialysis Coordinators Have Complete and Accurate Information on Community Dialysis Providers

During the referral process, dialysis coordinators are supposed to use PPMS to determine whether a provider is an NDSC or CCN provider. However, the Government Accountability Office (GAO) previously reported on problems with the accuracy of some PPMS data. For example, GAO identified numerous examples of inaccurate or incomplete demographic information in PPMS, including incorrect phone numbers, addresses, assigned care types, and providers who stated they no longer participated in the CCN.[53] Although the GAO did not specifically report on community dialysis services, the audit team found issues with dialysis provider data. The team determined that PPMS did not always include the information that would allow coordinators to comply with the required dialysis referral process. In particular, PPMS does not readily identify providers as affiliated with an NDSC and contains some inaccurate or incomplete community dialysis provider information.

This occurred because IVC had not taken steps to ensure all data in PPMS are accurate. IVC expanded the system in May 2022 when it uploaded data for approximately 7,400 NDSC providers. In doing so, IVC did not make sure users would be able to readily distinguish NDSC providers from other providers already captured in the system under "local contracts." The audit team assessed the provider data associated with local contracts in PPMS and was not always able to identify all NDSC providers. The team confirmed its results with the IVC program analyst

[52] *Community Care Field Guidebook.*

[53] GAO, *Veterans Community Care Program: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers*, GAO-23-105290, November 10, 2022.

familiar with the system, who reported there is nothing specific in the system to identify NDSC providers.

The team also found that PPMS contains some inaccurate and incomplete information on community dialysis providers because it is based on user-entered data. According to IVC's deputy director for administration (contract management) and a program manager with network support, data captured in the system are matched against the National Plan and Provider Enumeration System, the OIG's List of Excluded Individuals/Entities, and the System for Award Management.[54] However, the IVC program analyst reported the National Plan and Provider Enumeration System is not kept up to date by providers and includes old practice addresses, taxonomies that still identify providers as students, and errors in providers' names. Until IVC ensures the accuracy of PPMS data, coordinators will not have the information necessary to make dialysis referrals in accordance with VHA's requirements.[55]

In November 2022, the GAO recommended VA should review its processes for monitoring the accuracy and completeness of provider data in PPMS and implement strategies under current or future contracts to increase the accuracy of provider information. VA concurred with these recommendations and requested enhancements to PPMS that would create functionality for reporting provider demographic errors directly in PPMS. Further, IVC reported it would develop a review process to allow for proactive identification of provider data errors. In April 2023, VA's chief of staff informed GAO it is expanding resources in IVC to assist with reporting and validating provider data issues. This strategy is intended to improve the accuracy of contractor-submitted provider data in PPMS. IVC's hiring plan is underway with anticipated completion by the end of fiscal year 2023.

IVC Needs to Take Steps to Clarify Oversight Responsibilities for Community Dialysis Services

Lack of compliance with referral requirements went unnoticed because IVC has not assigned oversight responsibility for community care dialysis referral activities that occur at the medical facility level. The audit team found that several facility business lines are represented in the referral process that do not share the same reporting chain or requirements. These situations could complicate oversight of how facility dialysis coordinators refer veterans for dialysis care in

[54] CMS's National Plan and Provider Enumeration System provides unique identifiers for healthcare providers and plans. The List of Excluded Individuals/Entities includes all individuals and entities currently excluded from federally funded healthcare programs for a variety of reasons, including a conviction for Medicare and Medicaid fraud. The System for Award Management is used to register to do business with the US government including updating, renewing, or checking the status of entity registration and searching for entity registration and exclusion.

[55] Figure 1 details the required process that medical facility dialysis coordinators should follow when referring veterans to the community for dialysis services.

the community.[56] According to the team's survey, coordinators can be community care employees, social workers, or staff from other service lines. Some dialysis coordinators formally have the coordinator title, while others are informally named to the position, making it difficult to identify coordinators. In addition, when the team contacted Veterans Integrated Service Networks' dialysis leads to ask if they were performing any monitoring of the NDSC services, most leads reported they were not.[57]

Without assigned roles and responsibilities, dialysis coordinators may not always be aware of and follow the proper program procedures, including the required referral process for community-based dialysis care.[58] This also affects VHA's ability to oversee NDSC dialysis services. Only about 28 percent of coordinators reported to the team's survey that they contacted a contracting officer's representative when they had a question on the NDSCs. IVC should take action to establish roles and responsibilities to make sure dialysis coordinators follow required procedures when referring veterans to dialysis care in the community and understand whom to contact when they have questions about these services. Such action is consistent with GAO standards for establishing an organizational structure, assigning responsibility, and delegating authority to drive change.[59]

IVC Did Not Effectively Use Available Data on Dialysis Services in the Community

IVC does not monitor the capacity of the CCN to meet veteran demand for dialysis services, including where the capacity exists and the extent to which it is being used. IVC relies on CCN third-party administrators to expand the network's capacity to provide community care services. CCN third-party administrators are required to maintain an adequate network, and the network must be customized for each VHA medical facility's service area. However, VHA exempted the third-party administrators responsible for the CCN from reporting on the adequacy of their networks to provide dialysis. According to an IVC program manager involved with monitoring network adequacy, this exemption was provided because NDSCs provide the majority of services to veterans in the community. Although the third-party administrators are exempt from reporting on the adequacy of their networks for providing dialysis services, IVC should still monitor veteran access to and use of community dialysis services.

[56] According to the audit team's survey of 141 VA facility dialysis coordinators, 66 (about 47 percent) are aligned under social work, 51 (about 36 percent) are aligned under IVC, and 24 (17 percent) fall under some other designation.

[57] In October 2021, the audit team contacted dialysis leads at 17 Veterans Integrated Service Networks; an additional network reported not having a dialysis lead.

[58] *Community Care Field Guidebook.*

[59] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

For example, by analyzing the use of community dialysis providers in Chicago, the audit team identified opportunities for VHA to fully leverage CCN capacity in the area. In short, conducting this kind of analysis could alert IVC to opportunities third-party administrators are missing to expand veterans' access to CCN dialysis providers and inform its decisions about where to reduce or expand the number of NDSC providers. Doing so is also particularly important at this time because any future contracts VHA awards to replace the current NDSCs must comply with the MISSION Act, which requires VHA to pay community providers Medicare rates to the extent practicable.

VHA Relies Heavily on NDSC Providers and Is Not Fully Using Available CCN Dialysis Providers

VHA refers most veterans who receive dialysis care in the community to NDSC providers. From October 2020 through September 2022, about 20,800 veterans received dialysis services from NDSCs, compared to about 1,200 veterans who received services from CCN providers.[60] There are significantly more NDSC providers than CCN providers operating across the continental United States. However, the team found there were some areas with unused CCN providers. Figure 2 details NDSC providers with paid claims in gold and CCN dialysis providers without paid claims in teal.

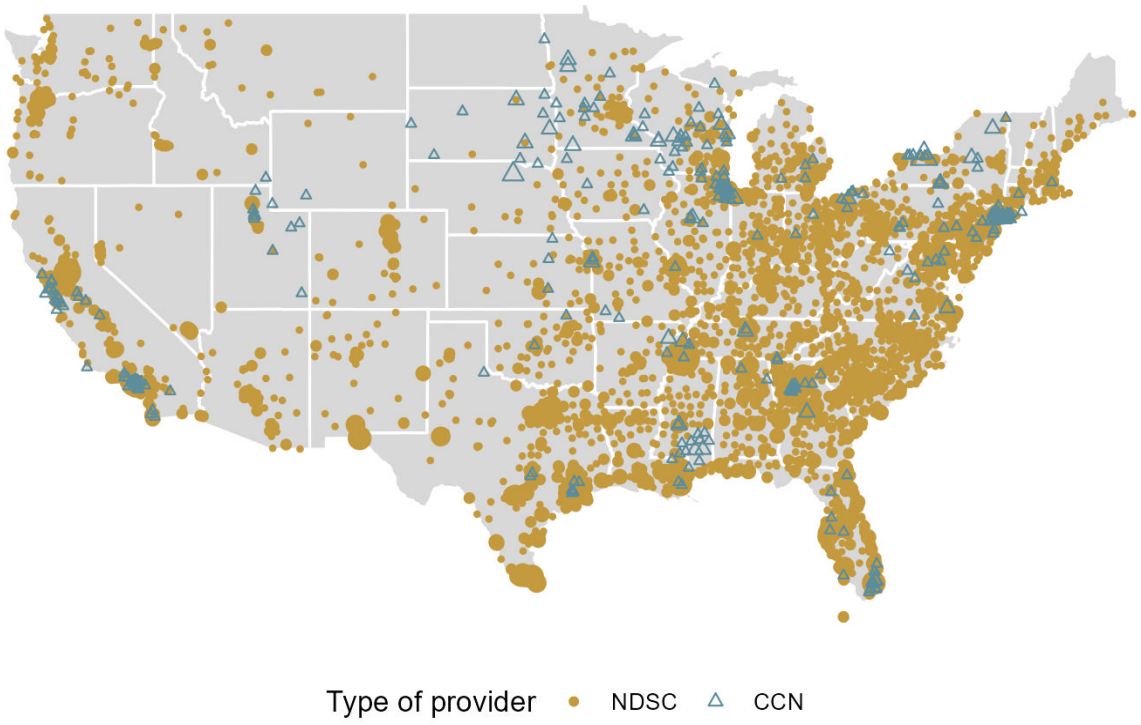

Figure 2. *Map of NDSC and CCN dialysis providers from October 2020 through September 2022.*

[60] In performing this assessment, the audit team considered unique veterans at 154 VHA medical facilities.

Source: VA OIG analysis of paid NDSC and unpaid CCN claims data from October 2020 through September 2022, as of December 2022.

Note: The size of each marker is proportionate to the number of providers (with the smallest size indicating one provider and the largest indicating nine providers) located in the zip code.

Table 4 identifies the type of providers that provided dialysis care to veterans during the team's review period.[61]

Table 4. Dialysis Services Usage Overview

Dialysis provider type	Number of veterans	Percentage
NDSC	19,591	75.7
VHA medical facility	4,857	18.8
CCN	1,069	4.1
VCA	322	1.2
Local	14	Less than 1 percent
Other*	13	Less than 1 percent

Source: VA OIG analysis of encounter and paid community dialysis claims during fiscal years 2021 and 2022 as of November and December 2022 respectively.

Note: This table identifies the first dialysis provider by considering the earliest encounter or paid claim for veterans receiving dialysis services and the provider associated with that encounter or claim during the team's review period. The percentages in the table are rounded. This table may not include all claims for dialysis services for fiscal years 2021 and 2022, because some claims may not have been processed when the data were obtained in December 2022.

**The audit team determined 14 dialysis providers were identified in claims data that did not match any of the NDSC, CCN, or VCA provider data using national provider identifiers and zip codes. A VHA manager familiar with network adequacy reported this may have occurred due to the necessary provider information not being in PPMS.*

Table 5 shows the total number of providers and dollars paid to NDSC, CCN, and VCA dialysis providers from October 2020 through September 2022. NDSC providers were paid about $1.2 billion, whereas CCN providers were paid about $44 million during fiscal years 2021 and 2022.

[61] The audit team did not identify any encounters at the three joint VA and Department of Defense dialysis sites identified by VHA during the period reviewed.

Table 5. Amounts Paid for Contracted Community Dialysis Services

Dialysis provider type	Number of providers paid in fiscal year 2021	Number of providers paid in fiscal year 2022	Total amount paid in fiscal years 2021 and 2022 (rounded in millions)
NDSC	5,208	5,243	$1,223.6
CCN	296	266	$43.7
VCA	79	73	$13.1
Local	6	3	$0.2
Other*	12	10	$0.6

Source: VA OIG analysis of paid community dialysis claims during fiscal years 2021 and 2022, as of December 2022.

Note: This table may not include all claims for dialysis services for fiscal years 2021 and 2022 because some claims may not have been processed when the data were obtained in December 2022.

**The audit team determined 14 dialysis providers were identified in claims data that did not match any of the NDSC, CCN, or VCA provider data using national provider identifiers and zip codes. A VHA manager familiar with network adequacy reported this may have occurred due to the necessary provider information not being in PPMS.*

By reviewing VHA provider information, the audit team determined the number of CCN dialysis providers is growing nationwide, but VHA is not fully utilizing this capacity. The team analyzed the number of NDSC and CCN providers with claims paid and without claims submitted in the continental United States from October 2020 through September 2022. The team found that during this period, VHA did not use 365 of 698 CCN providers (about 52 percent).[62] Of note, according to PPMS data, the number of CCN dialysis providers across the United States that were active between March 2020 and December 2022 increased by 524 facilities—from 149 to 673. The difference between the 673 CCN dialysis providers and the 698 is that the 673 CCN providers represent facilities that were identified in PPMS as "active" in each PPMS list from March 2020, June 2022, and December 2022.[63] Analysis of available claims and provider data could help IVC identify opportunities to better use available CCN capacity.

VHA Is Paying Different Rates for Comparable Services

In fiscal year 2022, there were nine NDSCs with rates ranging from [redacted] percent of the Medicare rate to [redacted] percent in the continental United States. Most veterans received care from only two of the nine NDSC providers—about 42 percent at contractor B and 45 percent at contractor E.

[62] The audit team identified 698 CCN dialysis providers in the continental United States from October 2020 through September 2022. The team confirmed these providers were with the CCN by matching the claims to PPMS provider lists. One provider was identified as a CCN dialysis provider but was not on the PPMS list from December 2022. It should be noted that some CCN providers became inactive at some point before December 2022.

[63] See appendix A for information on the audit team's data reliability assessment.

While reviewing the rates for dialysis options available to veterans in the community, the audit team identified multiple geographic areas where contractors were being paid different rates for similar services. The team also found VA's contract documentation did not include justification for paying different rates above the Medicare rate for comparable dialysis services provided to veterans in the same areas.[64] The earlier discussion on VHA usage of providers in Chicago, Illinois, as well as the discussion below regarding Las Vegas, Nevada, illustrates this point.[65] In the case of Chicago, the four NDSC providers that operate in that area, and even in the same zip code, are paid different rates that range from [redacted] to [redacted] percent of the Medicare rate. VA should conduct similar analyses to determine whether rate differences in geographic locations are warranted for any future dialysis contracts.

Las Vegas, Nevada

From October 2020 through September 2022, two nationwide dialysis contractors—contractors B and E—provided dialysis services to veterans in Las Vegas. In addition, there were two locally contracted providers, J and K; provider J provided dialysis services to veterans, while K did not have paid claims during this time. Figure 3 provides an overview of the dialysis providers in this area.

[64] According to 38 U.S.C. § 1703(i), VHA rates for medical care may not exceed the rate paid by the United States under the Medicare program unless the services are provided in a highly rural area, Alaska, and states with an all-payer model. Section 17.4035(d) states the factors that could prove persuasive in terms of determining impracticability as identified in the proposed rule include patient needs, market analyses, and healthcare provider qualifications.

[65] Appendix A provides additional details on the audit team's methodology.

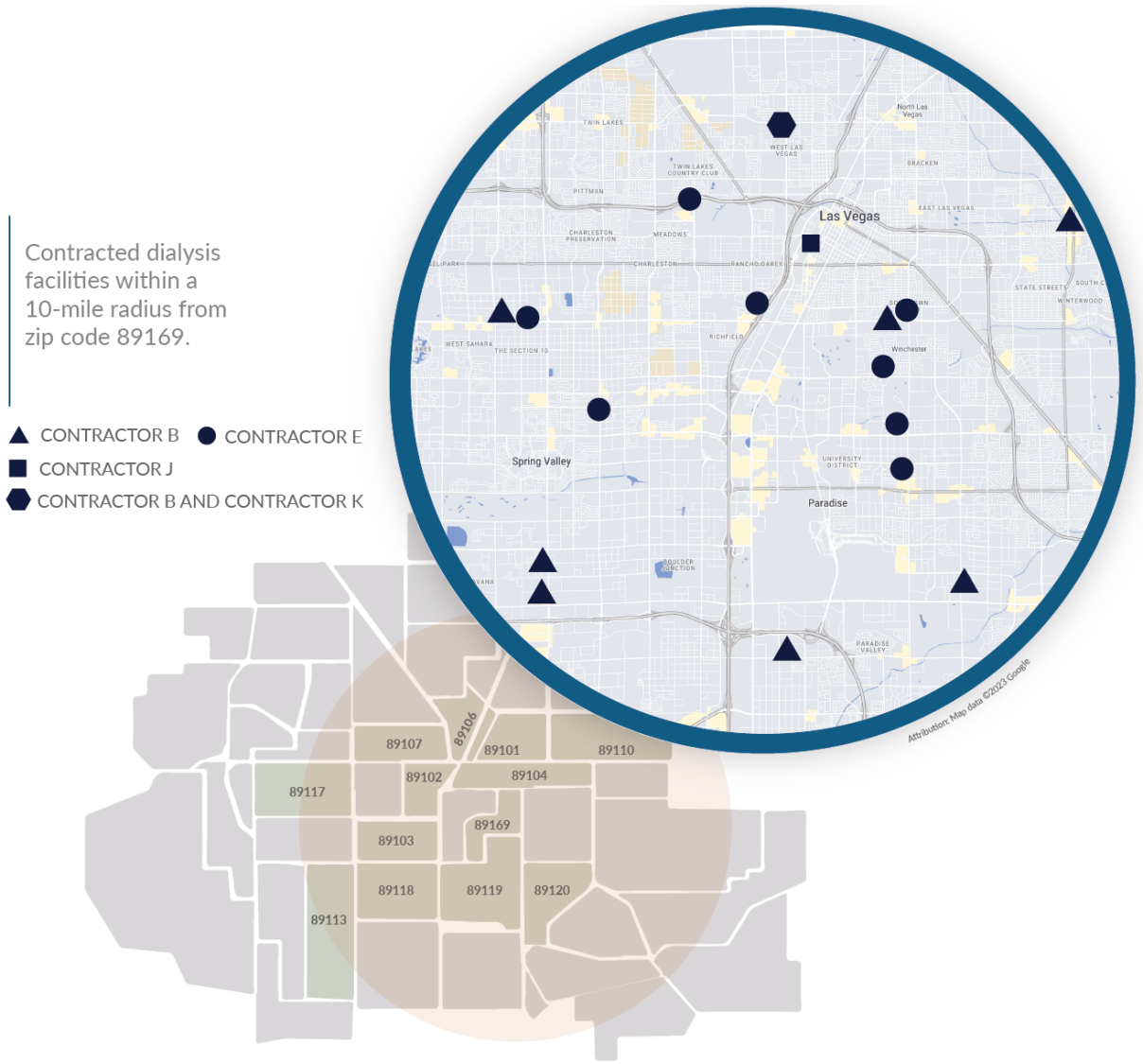

Figure 3. *Map of contracted dialysis providers in Las Vegas, Nevada.*

Source: VA OIG analysis of community dialysis provider data and paid community dialysis claims from October 2020 through September 2022, as of December 2022.

Las Vegas has 46 zip codes.[66] In 19 zip codes, contractors B, E, or both provided contracted dialysis services to veterans, and VA paid at least [redacted] percent above the Medicare rate at some point between October 2020 and September 2022. Contractor K was also in one of the 19 zip codes, while contractor J was in a zip code without other contracted providers. The VA Southern Nevada Healthcare System in North Las Vegas was unable to provide the audit team with the

[66] This analysis did not include nonstandard zip codes, including zip codes associated with post office boxes.

contract rates for the local contracts. Table 6 shows the differences in payments to these providers.

Table 6. Community Dialysis Contractors in Las Vegas

Contractors	Contract rate compared to the Medicare rate	Number of zip codes*	Contracted dialysis providers in those zip codes	Claims paid	Total amount paid (rounded in millions)
Contractor B	[redacted]	10	11	10,959	$4.6
Contractor E	[redacted]	12	14	13,672	$5.4
Contractor J	Unknown	1	1	68	$0.02
Contractor K	Unknown	1	1	0	0

Source: VA OIG analysis of paid community dialysis claims during fiscal years 2021 and 2022 as of December 2022.

Note: This table may not include all claims for dialysis services for fiscal years 2021 and 2022 because some claims may not have been processed when the data were obtained in December 2022.

**A provider could operate in more than one zip code.*

Some NDSC Providers Accept Medicare Rates in the Same Geographic Locations Where VHA Pays Higher Rates

The audit team's assessment also shows that some NDSCs are accepting lower rates from others than what they currently receive from VA for the same dialysis services. According to federal regulations, contract files must include sufficient documentation to constitute a complete history of the transaction. This complete background allows for informed decisions at each step in the contracting process.[67] However, the VA contracting officer responsible for the contracts and the IVC regional officer responsible for the NDSC contracting officer's representatives reported they were unable to find any documentation to justify the NDSCs' rates or the lack of price consistency for contracted services in the same geographic area. IVC's director of policy and planning agreed that federal regulations require a documented justification for exceptions. Although the OIG recognizes that the MISSION Act was not a consideration with the prior NDSCs, VA must consider all available provider data and develop a strategy that ensures its future dialysis contracts comply with payment requirements. This strategy should include an analysis of where veterans are already receiving services, and an analysis of the rates, locations, and demand for community dialysis services nationwide for all contracted providers.

[67] FAR 4.801 and 4.803 (2019).

NDSC providers serve most veterans who receive dialysis services in the community, and the audit team found this was also the case in Las Vegas and Chicago. To assess the different rates being paid in these cities, the team collaborated with the Department of Health and Human Services OIG to obtain information about NDSC providers that offered dialysis services at the Medicare rate between October 2020 and September 2022. Analysis of the data revealed the following:

- In Las Vegas, 24 NDSC providers treated both VA and Medicare patients.
    - These NDSC locations provided dialysis services to more Medicare patients than veterans—from 5.3 to about 116 times more.
    - VA paid between [redacted] percent and [redacted] percent more than Medicare per claim for the same services.
- In Chicago, 38 NDSC providers treated both VA and Medicare patients.
    - These NDSC locations provided dialysis services to more Medicare patients than veterans—from 5.5 to 91 times more.
    - VA paid between [redacted] percent and [redacted] percent more than Medicare per claim for the same services.

Based on the audit team's assessment of Las Vegas and Chicago, IVC may want to consider the Department of Health and Human Services' nationwide dialysis data when developing its future contracting strategy.

IVC Did Not Have a Strategy to Support Future Community Dialysis Contracts in Compliance with MISSION Act Requirements

VA exercised option years for nine NDSCs, effective in October 2022, for fiscal year 2023. In June 2023, the VA contracting officer on the current NDSCs reported they had not had any discussions about a contracting strategy beyond September 2024, when these contracts are scheduled to end.

IVC is responsible for all community dialysis service contracts. However, the IVC executive director for network management needs to maintain engagement with stakeholders, such as VA contracting and VHA's Kidney Health Committee, and develop a strategy to meet its community dialysis care goals. The audit team recognizes that in January 2022 the acting chief medical officer for IVC began attending meetings of the Kidney Health Committee, which is charged with oversight of VA kidney health services.[68] According to its charter, the committee relies on a VHA community care subject matter expert to provide relevant information on dialysis services.

[68] VHA Directive 1053.

By sustaining this improved communication with the Kidney Health Committee, IVC will be in a better position to fulfill its role in supporting veterans' access to dialysis in the community.

Further, an IVC acting senior executive reported that IVC leaders had discussions surrounding the operational efficiencies gained by consolidating the NDSC providers with future CCN contracts. Doing so should help IVC better align the rates that it is paying for all community dialysis services with MISSION Act requirements. However, the audit team found that while some IVC officials reported being aware of VHA's intent to transition from NDSCs to CCN contracts for dialysis services, they were not involved in developing or executing a strategy to realize this goal.

According to the contracting officer, planning for contracts to replace the expiring NDSCs should have started by January 2023. The contracting officer also noted this effort should include determining reasonable rates for dialysis services in the community. On August 18, 2023, IVC provided the OIG a charter for the integrated project team responsible for developing a strategy for awarding future NDSCs. (The draft date of the charter was August 15, 2023.) According to the charter, the team is responsible for developing a strategy to research and develop actionable recommendations. The OIG recognizes that IVC is now taking steps to develop a strategy, but the OIG does not have an opinion on this charter as it was provided after the audit work was conducted.

As VHA seeks to award future contracts, it must evaluate the availability of community dialysis services and rates and either meet the MISSION Act requirements or justify any exceptions. According to the act, VHA rates for medical care may not exceed the rate paid by the United States under the Medicare program unless the services are provided in a highly rural area or another specific exception applies.[69] Until IVC evaluates the availability of community dialysis services and rates and engages all stakeholders, it is missing opportunities to develop an evidence-based strategy for future contracts.

Conclusion

IVC is not leveraging information on available CCN dialysis providers or information from stakeholders to support its next contracting effort and comply with the MISSION Act. From October 1, 2020, through September 30, 2022, VHA spent about $1.2 billion on dialysis services. However, the audit team found some dialysis coordinators may not have access to accurate information to first refer veterans who require community dialysis services to available CCN providers as required. In addition, some coordinators are not performing dialysis facility searches in the manner required. Because guidance does not clearly establish roles and responsibilities and dialysis coordinators may not have the same reporting chain or requirements, IVC is not

[69] 38 C.F.R. § 17.4035.

effectively monitoring compliance with the referral process. In addition, IVC has not collected and analyzed available data on NDSC and CCN usage and rates.

By improving oversight and analyzing readily available data on community dialysis services, IVC will be better positioned to meet its goal of transitioning providers to the CCN while ensuring MISSION Act payment rate compliance. Given that NDSC providers charge at least 15 percent over the Medicare rate for dialysis, transitioning veterans to the CCN could result in cost savings to VA. However, IVC's strategy going forward should include steps to mitigate the impact to veterans already receiving these services.

Recommendations 1–4

The OIG made the following recommendations to the under secretary for health:

1. Clarify guidance to ensure it includes local dialysis contract options and specifically defines when they should be used.[70]
2. Establish roles and responsibilities to ensure dialysis coordinators follow required procedures when referring veterans to dialysis care in the community.
3. Develop and implement a plan to regularly examine and validate dialysis provider information in the Provider Profile Management System for accuracy and completeness.
4. Develop and implement a strategy to ensure that any new dialysis service contracts follow the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 payment rate requirements.

VA Management Comments

VHA's under secretary for health concurred with all four recommendations and submitted an acceptable corrective action plan with an anticipated completion date of December 2023. To address recommendation 1, IVC will clarify guidance related to "the hierarchy of purchased care options" to ensure it includes local dialysis contract options and defines when those options should be used. In response to recommendation 2, IVC will update guidance to ensure roles and responsibilities are clearly defined for VHA facility personnel involved with coordinating community dialysis services. To address recommendation 3, IVC is hiring a team to develop a series of periodic reviews of the dialysis provider information captured in PPMS and perform work to improve the quality of the data. Finally, to implement recommendation 4, VA will research strategies regarding market-specific analysis and service utilization in both VA and

[70] The phrasing of recommendation 1 was altered slightly for clarity after concurrence by the under secretary for health.

community care, as well as determine veterans' needs by location to inform potential market rate determination. Appendix B provides the full text of the under secretary's comments.

OIG Response

The under secretary for health's comments and corrective action plan are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides evidence demonstrating sufficient progress in addressing the issues identified.

Appendix A: Scope and Methodology

Scope

The audit team conducted its work from August 2021 through July 2023. The team assessed whether the Veterans Health Administration (VHA) effectively provides veterans access to community dialysis services by evaluating if VHA followed its prescribed referral process, which prioritizes the use of available community care network (CCN) providers over nationwide dialysis services contract (NDSC) providers.

Methodology

To assess whether VHA effectively provides veterans access to community dialysis services, the audit team used multiple sources of information, including applicable federal regulations and standards, VA policies and procedures, and acquisition regulations and guidance applicable to the contracts. The team reviewed 18 NDSCs and five CCN contracts, related contract documentation, and provider information. Further, the team obtained information from personnel at the Office of Acquisition, Logistics, and Construction; the Office of Integrated Veteran Care (IVC); the National Kidney Program; and the Financial Services Center. The team also interviewed members of the Kidney Health Committee.

To gain a better understanding of community dialysis services, the audit team interviewed personnel at judgmentally selected VHA medical facilities and network personnel in Veterans Integrated Service Networks. The team also reviewed prior audit work and recommendations related to VA contracted services, including a VA Office of Inspector General (OIG) report on IVC's oversight of non-VA healthcare claims processed by a contractor.[71] The team determined these reports had no direct relevance to VA dialysis contracts and, therefore, did not directly address recommendations from these reports during the audit. However, the team identified one Government Accountability Office (GAO) report that pertained to the audit.[72] The report detailed data errors in the Provider Profile Management System (PPMS) and recommended VA take steps to improve the accuracy of these data. In addition, the team coordinated with OIG procurement analysts about the audit finding.

Further, the audit team analyzed dialysis contract claims data and conducted a survey to collect information on how VHA uses contracted community dialysis services.

[71] VA OIG, *The Office of Community Care's Oversight of Non-VA Healthcare Claims Processed by Its Contractor*, Report No. 19-06902-23, March 2, 2021.

[72] GAO, *Veterans Community Care Program: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers*, GAO-23-105290, November 10, 2022.

Analysis of Dialysis Services Data

In December 2022, the audit team obtained computer-processed data on the providers, referrals, procedures, and claims from VA's Corporate Data Warehouse for dialysis services provided to veterans through the NDSCs, the CCN, veterans care agreements (VCAs), and local contracts for fiscal years 2021 and 2022. The data cover claims with a date of service between October 1, 2020, and September 30, 2022. Claims data came from two different data sources. The team obtained Plexis claims for NDSC providers from the "CBOPC_Data" data table, and CCN, VCA, and local contract claims from the "CDWWork" data table. The OIG updated its methodology to consolidate VHA community care claims data in May 2023, following notification from the VHA Office of Integrity and Compliance of data quality issues with one of the primary community care data sources. The team's counts and dollar totals may understate the true extent of dialysis services rendered during fiscal years 2021 and 2022, since those data relied on the affected data source.

Although VA and the Department of Defense have an agreement to share healthcare resources in specific locations, the team did not identify any claims associated with the three joint VA and Department of Defense dialysis sites identified by VHA during the period reviewed. Plexis claims data were identified by referral category and the current procedural terminology code associated with center-based hemodialysis (R0821/90999). Claims were also filtered for provider identifiers associated with the nine NDSCs under review. CCN, VCA, and local contract claims data were filtered by (1) place of service as dialysis clinic, (2) billing (national provider identifier) taxonomy as "End-Stage Renal Disease (ESRD) Treatment Clinic/Center," and (3) current procedural terminology code as 90999. The team excluded claims with a blank social security number or a social security number of 999999999.

Claims with a zero dollar or negative payment amount or total cost value were also excluded. Claims data were summarized at the national level and by period. The audit team used provider identifiers and zip codes obtained from IVC to match to NDSC, CCN, VCA, and local contract provider data to determine if claims were associated with more than one provider type. This match identified 8,041 providers in 5,306 zip codes across the United States and the team used this information to map the locations of contracted dialysis providers. The team also identified 7,937 providers in 5,228 zip codes in the continental United States. These matches represented dialysis providers located in these zip codes at a time during the audit.

The team analyzed data for dialysis providers located in Chicago, Illinois and Las Vegas, Nevada to identify amounts paid to providers in those locations. The team selected these two locations for illustrative purposes, as they were representative of different distributions of community dialysis providers. The Department of Health and Human Service's OIG analyzed data for these same providers to identify amounts paid for Medicare recipients at the same locations. Table A.1 summarizes the average total payments by VHA for contracted dialysis services in the community.

Table A.1. Average Amounts Paid for Contracted Dialysis Services in the Community

Entity	Average amount paid in fiscal year 2021	Average amount paid in fiscal year 2022	Average amount paid in fiscal years 2021 and 2022
NDSC			
Contractor A*	[redacted]	[redacted]	[redacted]
Contractor B	[redacted]	[redacted]	[redacted]
Contractor F	[redacted]	[redacted]	[redacted]
Contractor D	[redacted]	[redacted]	[redacted]
Contractor E	[redacted]	[redacted]	[redacted]
Contractor G	[redacted]	[redacted]	[redacted]
Contractor H	[redacted]	[redacted]	[redacted]
Contractor I	[redacted]	[redacted]	[redacted]
Contractor C*	[redacted]	[redacted]	[redacted]
CCN †			
Region 1	[redacted]	[redacted]	[redacted]
Region 2	[redacted]	[redacted]	[redacted]
Region 3	[redacted]	[redacted]	[redacted]
Region 4	[redacted]	[redacted]	[redacted]
VCA	[redacted]	[redacted]	[redacted]
Local	[redacted]	[redacted]	[redacted]

Source: VA OIG analysis of NDSC, CCN, VCA, and local contract paid dialysis claims during fiscal years 2021 and 2022 as of December 2022.

**These contractors provide community dialysis services to veterans located outside the continental United States.*

† *There are five CCN regions. There were no claims paid for outpatient hemodialysis services in CCN region 5 during the periods referenced.*

Note: Numbers in the table are rounded.

The audit team obtained Decision Support System cost and encounter data from VA's Corporate Data Warehouse for dialysis services provided to veterans through VHA medical facilities for fiscal years 2021 and 2022 from October 1, 2020, through September 30, 2022; the data were obtained in November 2022. The team analyzed the data to determine the cost for services

designated with a stop code 602 (for assisted hemodialysis).[73] Decision Support System encounter data were filtered to exclude encounters that did not have a current procedural terminology code recorded as 90999 in the 25 terminology codes associated with each encounter. The team also excluded VA encounters with a payment amount or total cost value of zero dollars and those with a negative amount. The costs for VA medical facility encounters were based on the recorded "ACTTOTCOST" (or actual total cost) associated with each encounter.

Surveys of VHA Personnel about Contracted Dialysis Services

The audit team identified VHA medical facility contacts responsible for coordinating non-VA dialysis referrals from medical facilities to contracted dialysis facilities. These individuals typically coordinate the consults, referrals, and authorizations for veterans who receive care from community dialysis facilities. From October 26 through November 16, 2021, the team conducted an online survey of 141 medical facility coordinators.

This survey was designed to collect information to help the audit team gain a better understanding of how VHA's medical facilities use the dialysis contracts to provide veterans with access to dialysis treatment. All coordinators responded to the survey. To better understand some of the responses, the team contacted eight of the respondents and some referred the team to local social workers for additional information on community dialysis services.

Internal Controls

The audit team assessed the internal controls for community dialysis services significant to the audit objective. This included an assessment of the five internal control components including control environment, risk assessment, control activities, information and communication, and monitoring.[74] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following three components and three principles as significant to the objective.[75] The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies:[76]

- Component 1: Control Environment

[73] A stop code defines workload to support patient care, resource allocation, performance measurement, quality management, and third-party collections, whereas a current procedural terminology code defines a code for a service or procedure and is assigned to an encounter based on the clinical service or procedure performed at the time of the encounter.

[74] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-70G, September 2014.

[75] Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

[76] GAO, *Standards for Internal Control in the Federal Government*.

  - Principle 3: Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.
- Component 3: Control Activities
  - Principle 10: Management should design control activities to achieve objectives and respond to risks.
- Component 4: Information and Communication
  - Principle 13: Management should use quality information to achieve the entity's objectives.

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators within its data and documentation reviews, survey, and interviews of VA and VHA personnel involved with the delivery of community dialysis services. The OIG did not identify any instances of fraud during this audit.

Data Reliability

The audit team obtained dialysis claims data from the Corporate Data Warehouse to determine what was paid to dialysis contractors through the NDSCs, CCN, VCAs, and local contracts. The team compared claims payment data to information from the Financial Management System to identify incorrect or incomplete payment amounts. Further, the team compared some of its claim totals from October 1, 2020, through September 30, 2022, with VHA claims data to identify any differences and determine the reliability of these results.

The audit team also assessed the validity and reliability of computer-processed data. The team assessed the reliability of PPMS data by matching community dialysis provider claims data to the data in PPMS during the audit. The assessment included considerations regarding the completeness of this matching for purposes of the audit. In addition, the team considered information on NDSC, CCN, VCA, and local contract dialysis providers for the period reviewed and reconciled this information to identify payments made for community dialysis services. The team also discussed the reliability of payment data in these systems with VA personnel familiar with the data. Further, the team researched the status of 15 providers associated with the NDSCs, and 15 providers associated with the CCN that were included with provider data but did not have any claims volume for fiscal year 2021. The team researched these dialysis providers to determine if they were in business at some point during the audit. Based on this reliability assessment, the team concluded that the provider and claims data used during the audit were appropriate and sufficient.

The audit team obtained computer-processed Decision Support System cost data to determine the costs to provide dialysis services to veterans through VHA medical facilities. The team assessed the reliability of this cost data by comparing summary counts and totals by period to a Managerial Cost Accounting Office report. In addition, the team contacted VA personnel familiar with these data. Based on this reliability assessment, the team concluded that the data were appropriate and sufficient for the purposes of the audit.

Further, the audit team obtained the NDSCs and related documentation from VA's Electronic Contract Management System. The team confirmed the availability of contract documentation with VA. The team consulted with OIG procurement analysts about the relevant contract documentation. The team determined the documentation maintained in the Electronic Contract Management System was sufficiently reliable for the purposes of this audit. The team also conducted an online survey of dialysis coordinators to learn more about the program. The team took steps to validate the accuracy of the survey results, including ensuring respondents' results were not included more than one time and following up to clarify some responses. The team determined the survey data were sufficiently reliable. In addition, the Department of Health and Human Services OIG completed a quality assurance review of the data provided to the team. There were no changes to the data as a result of this review. The team reviewed these results to ensure they were consistent with the VHA community dialysis data used during the audit. The team considered these data sufficiently reliable for purposes of the audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix B: VA Management Comments

Department of Veterans Affairs Memorandum

Date: September 13, 2023

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, The Office of Integrated Veteran Care Needs to Improve Community Dialysis Oversight and Develop a Strategy to Align Future Contracts with the MISSION Act (OIG 2021-03102-AE-0150) (VIEWS 10684215)

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

1. Thank you for the opportunity to review and comment on the OIG draft report on community dialysis oversight. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.
2. VHA appreciates the work performed by the OIG. The continued partnership with the OIG is critical, particularly while we work through the contracting process for a replacement of National Dialysis Services Contract and Community Care Network.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal M.D., MBA

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, The Office of Integrated Veteran Care Needs to Improve Community Dialysis Oversight and Develop a Strategy to Align Future Contracts with the MISSION Act

(OIG 2021-03102-AE-0150)

Recommendation 1. The Under Secretary for Health clarifies guidance to ensure it includes local dialysis contract options to specifically define when they should be used.

VHA Comments: Concur

The Office of Integrated Veteran Care (IVC) will review and update the IVC Field Guidebook to clarify guidance related to the hierarchy of purchased care options to ensure it includes local dialysis contract options to specifically define when those options should be used. IVC will share updates with facility community care offices through established update calls such as, IVC Network Management Field Update Call, Consult Performance Improvement Call (PI), Access Community of Practice (CoP) Call and IVC Clinical Office Hours.

Status: In Progress Target Completion Date: December 2023

Recommendation 2. The Under Secretary for Health establishes roles and responsibilities to ensure dialysis coordinators follow required procedures when referring veterans to dialysis care in the community.

VHA Comments: Concur

IVC will collaborate with relevant program offices, as well as Veterans Integrated Service Network and VA medical center subject matter experts, to define roles and responsibilities for facility staff involved in the coordination of dialysis through community care. IVC will review and update the IVC Field Guidebook to ensure defined roles and responsibilities, as well as required procedures for referring Veterans to dialysis care in the community, are clearly defined for personnel performing those functions. IVC will share updates with VA facility staff through established update calls such as IVC Network Management Field Update Call, Consult PI Call, Access CoP Call, IVC Clinical Office Hours.

Status: In Progress Target Completion Date: December 2023

Recommendation 3. The Under Secretary for Health develops and implements a plan to regularly examine and validate dialysis provider information in the Provider Profile Management System for accuracy and completeness.

VHA Comments: Concur

To examine and validate dialysis provider information in the Provider Profile Management System (PPMS), IVC is hiring a data team to develop a series of periodic reviews of the data and perform work to improve the data quality. IVC anticipates the team will be onboarded by end of fiscal year 2023. Once the team is on board, a plan will be developed to regularly examine and validate dialysis provider information in PPMS.

Status: In Progress Target Completion Date: December 2023

Recommendation 4. The Under Secretary for Health develops and implements a strategy to ensure that any new dialysis service contracts follow the John S. McCain III, Daniel K. Akaka, and Samuel

R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 payment rate requirements.

VHA Comments: Concur

VA is in the early stages of forming the acquisition strategy for the next version of the National Dialysis Services Contracts contract. VA will research strategies regarding market specific analysis, service utilization in both VA and community care, as well as determine Veterans' needs by location to inform potential market rate determination. VA will follow the VA Acquisition Lifecycle Framework for an acquisition of this size which includes formal governance structure, including an integrated project team charter to further develop additional specific contracting efforts in alignment with the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 and other requirements.

Status: In Progress Target Completion Date: December 2023

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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