VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Patient-Centered Community Care (PC3) Health Record Coordination

September 30, 2015
15-00574-501

ACRONYMS

CBO	Chief Business Office
COR	Contracting Officer's Representative
CPT	Current Procedural Terminology
EHR	Electronic Health Record
OIG	Office of Inspector General
PC3	Patient-Centered Community Care
PET	Positron Emission Tomography
QASP	Quality Assurance Surveillance Plan
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Report Highlights: Review of Patient-Centered Community Care (PC3) Health Record Coordination

Why We Did This Review

The Office of Inspector General (OIG) determined whether Patient-Centered Community Care (PC3) contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements. This is one of a series of reports addressing PC3 service delivery and contract issues.

What We Found

We estimate PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during our period of review from January 1, 2014, through September 30, 2014. We estimate that 48 percent of the clinical documentation was provided to VA late and 20 percent was incomplete. VHA made about $870,400 of improper payments when payments should not have been made prior to receiving complete clinical documentation.

VHA did not apply contract penalties to Health Net Federal Services, LLC when it did not meet performance requirements related to the timely return of clinical documentation. VHA applied a penalty of only $753. The maximum allowable penalty was $15,909. If VA exercises the remaining three option years of the PC3 contract without adequately addressing the identified issues, VA could make about $5.5 million in improper payments and missed assessed penalties.

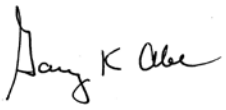
We also found that PC3 patients experienced delays in VHA referring and following up on their care with TriWest Healthcare Alliance Corporation (TriWest), as well as TriWest not timely notifying VHA of three malignancy diagnoses resulting from colonoscopies. These issues occurred because VHA relied on contractor-reported data, lacked an adequate program for monitoring contractor performance, and a process to verify whether the contractor meets contract performance standards. As a result, VHA lacked assurance that PC3 is providing patients adequate continuity of care.

What We Recommended

We recommended VHA implement a mechanism to verify PC3 contractors' performance, ensure PC3 contractors properly annotate and report critical findings in a timely manner, and impose financial or other remedies when contractors fail to meet requirements.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and provided an appropriate action plan. We will follow up on the implementation of the corrective actions.



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INTRODUCTION

Objective

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted this review to determine whether Patient-Centered Community Care (PC3) contractors provided clinical documentation and reported critical findings as specified in their contract performance requirements.

Background

PC3 is a Veterans Health Administration's (VHA) nationwide program that offers health care contracts to provide eligible veterans access to:

- Primary care[1]
- Inpatient and outpatient specialty care
- Mental health care
- Limited emergency care
- Limited newborn care for enrolled female veterans following delivery

The PC3 program is used after the VA medical facility has exhausted other options for purchased care and when local VA medical facilities cannot readily provide the needed care to eligible veterans due to lack of available specialists, long wait times, geographic inaccessibility, or other factors.

In September 2013, VA awarded Health Net Federal Services, Limited Liability Corporation (Health Net) and TriWest Healthcare Alliance Corporation (TriWest) PC3 contracts totaling approximately $5 billion and $4.4 billion, respectively. PC3 contracts were awarded to provide veterans with timely access to quality care when VHA facilities could not provide veterans with timely care.

Other Information

- Appendix A provides details on our scope and methodology.
- Appendix B provides details on our statistical sampling methodology.
- Appendix C discusses potential monetary benefits.
- Appendix D provides comments by the Under Secretary for Health.

[1] VA modified the PC3 contracts on August 8, 2014, to add primary care services.

RESULTS AND RECOMMENDATIONS

Finding 1 PC3 Contractors Did Not Return Clinical Documentation to VA as Required by the Contract

We estimate PC3 contractors did not meet the clinical documentation requirements for 68 percent of episodes of care during our period of review from January 1, 2014, through September 30, 2014. Of the 68 percent, we estimate that 48 percent of the clinical documentation was provided to VA late and 20 percent of the clinical documentation was incomplete. Only an estimated 32 percent of the episodes of care had complete clinical documentation provided within the time frame required under the PC3 contract. This was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation.

VHA made improper payments when, according to the contracts, payments should not have been made to Health Net and TriWest prior to receiving complete clinical documentation. We estimated 20 percent of the documentation was incomplete and provided to VA by PC3 contractors resulting in improper payments of about $5,400 to Health Net and $865,000 to TriWest from January 1 through September 30, 2014.

VHA applied a contract disincentive penalty of about $753 to Health Net for the period of July through September 2014. The penalty was for lack of performance related to timely providing clinical documentation to VA. We estimated the maximum allowable contract disincentive penalty that could be applied to Health Net's administrative fees was $15,909 for the period. By assessing the penalty at $753, VHA missed an opportunity to enforce performance requirements by penalizing Health Net an estimated $15,156. As of June 2015, we could not determine whether penalties were applied to TriWest, and how much could have been deducted because VA had not completed a timely review of TriWest's performance for the period of July through September 2014.

The PC3 contractors did not meet the clinical documentation requirements because VA lacked an effective program for monitoring the contractors' performance. Contracting Officer's Representatives (CORs) do not have an independent source of VA data to verify contractor compliance with the Quality Assurance Surveillance Plan (QASP) in the contracts. The primary tool used by CORs to verify contractors' compliance was monthly performance reports that were self-reported by the contractors. As a result, VA lacked adequate visibility and assurance that veterans are provided adequate continuity of care, and VA was at risk of improperly awarding incentive fees or not applying penalty fees.

Criteria

The PC3 contracts require the contractors to provide clinical documentation to VA within 14 calendar days upon completion of the episode of care for outpatient care and 30 business days from discharge for inpatient care. The contracts also state that when a gastroenterology procedure is performed and a specimen is removed for pathologic assessment, a copy of the pathology results must be included with the clinical documentation. Additionally, the contracts require that contractors not bill VA until they have submitted complete clinical documentation for both outpatient and inpatient care.

The Federal Acquisition Regulation requires QASPs be prepared in conjunction with contracts' statements of work during the contract award process. The QASP is the key Government-developed surveillance process document and is used to manage contractor performance assessment by ensuring that systematic quality assurance methods are used to validate the contractor's quality control efforts are timely, effective, and are delivering the results specified in the contract or task order. The QASP directly corresponds to the performance objectives and standards (that is, quality, quantity, timeliness) specified in the contract. It details how, when, and by whom the Government will survey, observe, test, sample, evaluate, and document contractor performance results to determine whether the contractor has met the required standards for each objective in the contract.

The PC3 contract's QASP specifies contractors must meet contract performance requirements 90 percent of the time for outpatient and 95 percent for inpatient documentation. The QASP further specifies that when the contractors fail to meet the performance thresholds, VA shall decrease the payment of administrative fees as a monetary disincentive.

What We Did

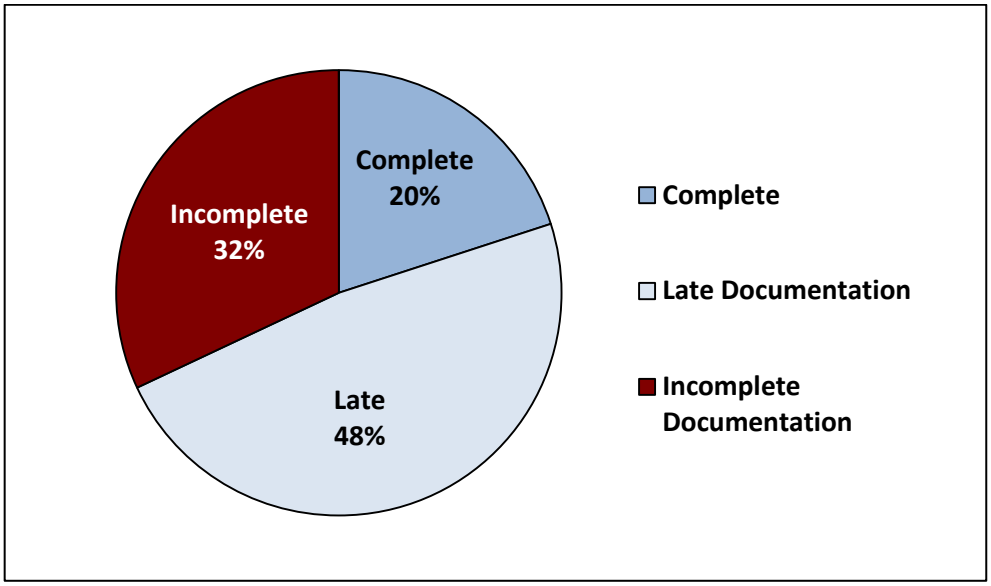
To determine whether Health Net and TriWest met their performance standards, we selected 433 payments (402 outpatient and 31 inpatient) made to them from January 1, 2014, through September 30, 2014. For each sample item, we first determined whether the clinical documentation was provided to VA, and if so, we then compared the date of the service with the date when the documentation was provided to VA. In instances where documentation was incomplete, we considered those sample items errors and did not use them for the calculation of contractor timeliness. For the documentation that was complete, we determined timeliness by comparing the last date of the outpatient episode of care with the date the documentation was made available to VA. Appendix A provides a more detailed description of our review methodology.

What We Found

We estimate PC3 contractors did not meet the clinical documentation requirements for 68 percent of inpatient and outpatient episodes of care from January 1, 2014, through September 30, 2014. Of the 68 percent, we estimate that 20 percent of the clinical documentation was incomplete and 48 percent of the clinical documentation was returned late. Only an

estimated 32 percent of the episodes of care had complete clinical documentation provided within the time frame required under the PC3 contract, which was well below the 90 percent contract performance standard for outpatient and 95 percent for inpatient documentation. The figure below summarizes the percentage of errors in each of the three categories.

Figure. Percentage of Clinical Documentation Errors by Type



Source: VA OIG analysis of paid non-VA medical care invoices

Incomplete Documentation

We estimate that PC3 contractors did not provide VA with complete documentation for 20 percent of outpatient and 19 percent of inpatient episodes of care. Table 1 provides estimates of outpatient and inpatient documentation errors by contractor during the period from January 1, 2014, through September 30, 2014. Both contractors provided clinical documentation to VA through secure Internet portals.

Table 1. Estimate of Incomplete Clinical Documentation Errors by Contractor

	Health Net	TriWest	Total
Outpatient	.3 percent	33 percent	**20 percent**
Inpatient	0 percent	20 percent	**19 percent**

Source: VA OIG analysis of paid non-VA medical care invoices

Clinical documentation was often not complete for veterans who received a colonoscopy procedure with a biopsy. Of the 402 outpatient episodes of care reviewed, 239 were colonoscopy procedures with a biopsy. Out of the

239 episodes of care, we found the contractors did not provide 91 pathology reports.[2] As shown in Table 2, this was an issue for both contractors.

Table 2. Incomplete Colonoscopy Procedure Clinical Documentation by Contractor

Error Type	Health Net	TriWest	Total
Total Procedures Reviewed	80	159	**239**
Procedure Report Not Provided	3	1	**4**
Pathology Report Not Provided	5	86	**91**
Both Reports Not Provided	1	22	**23**

Source: VA OIG analysis of gastroenterology clinical documentation provided by PC3 contractors

VHA Made Improper Payments

VHA made improper payments to PC3 contractors when payments were made to Health Net and TriWest prior to the return of complete clinical documentation. We estimated that 20 percent of the documentation returned by PC3 contractors was returned incomplete and therefore resulted in improper payments of about $5,400 to Health Net and $865,000 to TriWest from January 1, 2014, through September 30, 2014.

The PC3 contracts require the return of complete clinical documentation within 14 calendar days upon completion of the episode of care for outpatient care and 30 business days from discharge for inpatient care. It also states contractors are not to bill VA until they have submitted the required clinical documentation.

OMB Circular A-123 describes an improper payment as:

> *Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Incorrect amounts are overpayments or underpayments that are made to eligible recipients (including inappropriate denials of payment or service, any payment that does not account for credit for applicable discounts, payments that are for an incorrect amount, and duplicate payments). An improper payment also includes any payment that was made to an ineligible recipient or for an ineligible good or service, or payments for goods or services not received (except for such payments*

[2] Finding 2, later in the report, discusses the issue of identification and communication of critical findings more in depth.

> *authorized by law). In addition, when an agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.*

VHA needs to implement a mechanism to ensure it does not make payments to PC3 contractors until all required clinical documentation associated with an episode of care has been received.

Outpatient Documentation Timeliness

We found that Health Net and TriWest did not meet the PC3 timeliness contract performance standard of providing clinical documentation to VA within 14 calendar days upon completion of the episode of care for outpatient care. We estimated that PC3 contractors provided complete clinical documentation that met the timeliness standard for only 32 percent of outpatient episodes of care. Overall, it took an average of 44 days to return complete outpatient clinical documentation to VA.

We estimated 38 percent of Health Net's outpatient episodes of care had complete clinical documentation that met the PC3 timeliness standards. Health Net averaged 69 days to return complete clinical documentation after veterans received treatment. Its timeliness of submitting complete documentation ranged from 1 day to 257 days among the episodes of care we sampled.

We estimated TriWest met the timeliness standard for 29 percent of outpatient episodes of care. TriWest averaged 22 days to return complete clinical documentation. Its timeliness of submitting complete documentation ranged from 2 to 174 days. Both contractors fell below the QASP performance requirement of providing complete clinical documentation to VA 90 percent of the time for outpatient documentation.

Inpatient Documentation Timeliness

We also determined TriWest did not meet PC3 inpatient timeliness standards by providing complete inpatient clinical documentation to VA within 30 business days from discharge. Health Net met the timeliness standard for its one inpatient episode of care by submitting complete documentation in 6 days. We estimate TriWest met the timeliness standard for 23 percent of inpatient episodes of care. Its timeliness of submitting complete documentation ranged from 6 to 105 days. TriWest fell below the QASP performance requirement of providing complete clinical documentation to VA 95 percent of the time for inpatient documentation.

VHA Needs To Enforce Contract Performance Requirements

Clinical documentation was either incomplete or returned late because VA lacked effective controls to ensure PC3 contractors provided required supporting clinical documentation timely. In addition, VA paid PC3 contractors prior to receipt of completed documentation. CORs lacked an independent source of data to verify contractor compliance with the QASP.

The primary tool used by CORs to verify contractors' compliance was monthly reports self-reported by the contractors. CORs then compared the monthly reports with the contractors' detailed clinical documentation submissions on the contractors' Web portals.

The PC3 contracts and the accompanying QASPs have prescribed disincentive penalties for lack of performance related to the timely return of clinical documentation. According to each contract QASP, a penalty of up to 3 percent could be deducted from VA's administrative payment if Health Net or TriWest failed to meet key performance standards including clinical documentation timeliness. VA was entitled to assess penalties starting in July 2014, following the initial contract grace period.

VA applied penalties of only about $753 to Health Net from July through September 2014. We estimate that Health Net returned only 38 percent of the clinical documentation in accordance with the QASP, well below the 90 percent performance standard. Had VA calculated Health Net's performance using independent sources of data, VA could have penalized Health Net the maximum allowable penalty of $15,909 or an additional estimated $15,156.

As of June 2015, we were unable to determine whether penalties were applied to TriWest, and how much could have been deducted because VA had not completed a timely review of TriWest's performance for the period of July 2014 through September 2014. VA will need to complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.

VHA's Chief Business Office (CBO) Purchased Care Department of Audits and Internal Controls Special Audit Team completed an internal review of PC3 clinical documentation timeliness in September 2014. The Special Audit Team concluded the only data available to verify receipt of clinical documentation were self-reported contractor data. The team recommended VHA develop a means to validate the receipt of clinical documentation using an independent data source. According to the Special Audit Team it has implemented a plan to conduct periodic oversight. However, VHA has not developed an independent data source to validate the contractors' self-reported performance data. VHA needs to implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.

Conclusion

VHA needs more effective oversight of its PC3 contractors' performance ensuring complete clinical documentation is provided in a timely manner in order to provide continuity of care to our veterans. In order to monitor contractor performance, VHA needs to implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.

Without this mechanism, VHA will not achieve its intended purpose of ensuring PC3 is an effective alternative method to provide veterans additional access to health care.

Recommendations

1. We recommended the Under Secretary for Health implement a mechanism to ensure payments are not made to Patient-Centered Community Care contractors until all required clinical documentation is received.

2. We recommended the Under Secretary for Health enforce Patient-Centered Community Care contract performance requirements to ensure that contractors return complete clinical documentation timely.

3. We recommended the Under Secretary for Health implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.

4. We recommended the Under Secretary for Health complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.

5. We recommended the Under Secretary for Health review the contract disincentives applied to HealthNet and determine if additional funds need to be recouped from the contractor and pursue collection if disincentives were under applied.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendation 1 by August 2016, Recommendation 2 by April 2016, and Recommendations 3–5 by February 2016. The Under Secretary for Health's entire verbatim response is located in Appendix D.

OIG Response

The Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

Finding 2 PC3 Contractors Did Not Identify and Communicate Critical Findings to VA

We reviewed 433 sample episodes of care and identified 3 critical findings. The three critical findings of malignant colon tissue were discovered by TriWest providers. The providers had performed colonoscopies, biopsied polyps, and the results should have been reported to VA as critical findings. TriWest's monthly reports only reported one of the three critical findings. We could not find evidence that TriWest notified VA of the three critical findings within 48 hours as required under the provisions of the PC3 contract.

The PC3 contracts have specific terms and conditions to identify and report critical findings, and prescribe financial penalties for not doing so. However, after interviewing CORs and reviewing the QASP, we determined there was not an adequate process established for CORs to verify whether the contractor meets the contract's performance standard. As a result, VA has not assessed financial penalties or issued any corrective action letters related to critical finding reporting to enforce TriWest to meet contract performance standards.

Criteria

PC3 contracts outline special requirements for the contents and transmission of clinical documentation that contain critical findings. A critical finding is defined in the contract as findings, values, or interpretations that, if left untreated, could be life threatening or place the veteran at serious risk. The contracts require that a new diagnosis of cancer must be reported to VA within 48 hours of diagnosis.

The PC3 contract also requires the contractors to ensure that contact with VA is annotated in the impression section of the diagnostic imaging report or elsewhere in the clinical documentation for a non-imaging–related critical finding. The QASP specifies contractors must meet the contract performance requirements 90 percent of the time for outpatient documentation. The QASP further specifies that if the contractor does not meet the requirement of timely critical finding and urgent reporting, it can be financially penalized.

What We Did

For each sampled item, we reviewed the clinical documentation provided by the contractor as well as the veteran's Electronic Health Record (EHR) to identify any potential critical findings. When we identified a critical finding, we determined whether the critical finding was reported by the PC3 contractor in its monthly report submission to VHA's PC3 program office. We then reviewed the clinical documentation that was submitted by the contractor to determine whether the provider annotated its telephone contact with VA. Next, we reviewed the veteran's EHR to determine if timely

notification of the critical finding was documented. Finally, OIG Health Care Inspectors reviewed and verified the three critical findings. Appendix A provides a more detailed description of our review methodology.

What We Found

We reviewed 433 sample items and identified 3 critical findings. The three critical findings were related to TriWest's discovery of malignant colon tissue. We examined each critical finding of malignant colon tissue and found that PC3 patients experienced delays in VA referring and following up on their care with TriWest, as well as TriWest not reporting critical findings timely to VA.

TriWest providers had performed colonoscopies, biopsied polyps, and the results should have been reported to VA as a critical finding. The EHR was reviewed for each of the three patients and we found documentation of the diagnoses, but we could not find evidence that TriWest notified VA of the critical findings within 48 hours as required under the provisions of the contract. In fact, TriWest's monthly reports indicated only one critical finding had been reported but did not indicate whether it was timely reported. Table 3 shows the number of critical findings found in our sample and those reported by Health Net and TriWest.

Table 3. Critical Findings Reported by Contractor

	Health Net	TriWest	Total
Critical Findings Identified by OIG	0	3	**3**
Critical Findings Reported by Contractor on Monthly Report	0	1	**1**
Critical Findings Reported Timely by Contractor	0	0	**0**

Source: Analysis of clinical documentation provided by PC3 contractors

Critical Findings Not Annotated in Records by Providers

When we reviewed the critical findings identified in our sample, we expected to find an annotation made by TriWest's provider in the clinical documentation giving the name of a VA medical facility member contacted and the date and time of the contact. We did not find contract-required elements annotated in the clinical documentation returned by TriWest's providers. Without this information and the timely receipt of critical findings, VHA has little assurance that critical findings are being reported in accordance with the contract's performance standards. We examined each critical finding of malignant colon tissue and found that PC3 patients experienced delays in treatment by VA, as well as by TriWest.

Critical Finding 1 Reported by TriWest

A VA medical facility primary care provider saw a patient in November 2013 and ordered routine testing of the patient's stool for blood to screen for colon cancer. The subsequent laboratory evaluation determined that the patient's stool contained microscopic blood. Following the notification of the laboratory results in December 2013, an authorization for a colonoscopy under the PC3 program was completed and faxed to TriWest 47 days after the patient was referred for care outside VA. In May 2014, 113 days after the authorization was sent to TriWest, the patient received a screening colonoscopy from a TriWest provider that included the removal of specimens for pathological assessment. Seven days after the completion of the assessment, TriWest notified the VA medical facility of the critical finding of adenocarcinoma.[3] Medical facility staff notified the patient the same day that the critical result was received from TriWest's provider. After being notified, the patient elected to seek treatment in the private sector at his own expense. The total duration of the episode of care was 167 days.

Critical Finding 2 Not Reported by TriWest

During a routine lab test in April 2014, VA medical facility staff identified blood in a patient's stool. The medical facility placed an order for an urgent colonoscopy on the same day. VA medical facility staff faxed a consult to TriWest 4 days later to receive care under the PC3 contract. However, the patient did not receive a colonoscopy from TriWest's provider until 50 days later in June 2014. TriWest did not notify the VA medical facility of the new malignancy until 16 days later when the clinical documentation was provided to VA. On the same day the clinical documentation was received, VA notified the patient of the critical result. The patient elected to pursue treatment for the identified malignancy outside VA at his own expense. The total duration of the episode of care was 70 days.

Critical Finding 3 Not Reported by TriWest

In May 2014, a VA medical facility referred a patient to TriWest for a screening colonoscopy following a positive colon-cancer screening test for blood in the stool. The colonoscopy was completed by a TriWest provider 6 days after being referred. The patient then saw a VA medical facility surgeon in June 2014, 16 days after the screening colonoscopy to discuss treatment options. However, the VA surgeon had not yet received the pathology report for the screening colonoscopy from TriWest's provider, and therefore, could not make treatment plans. Following the appointment, the surgeon asked Non-VA Care staff to obtain the patient's pathology report. The pathology results were provided in June 2014 by the TriWest provider, 23 days after the screening colonoscopy was performed. After receiving the pathology results, treatment plans were made for the patient. The total duration of the episode of care was 29 days.

[3] Cancer that develops in the intestinal gland cells that line the inside of the colon and/or rectum is an adenocarcinoma.

VA Needs To Follow Up PC3 Encounters and Enforce Contract Terms

Although the PC3 contract has specific terms and conditions to identify and report critical findings and financial penalties for not doing so, we did not find evidence that CORs had an adequate process for identifying contract non-performance. CORs stated that they often do not receive critical finding notifications until the PC3 contractor submits its monthly report. Additionally, we have identified in our review that not all critical findings are reported by the contractor in its monthly report.

VA needs to establish an effective follow-up process to ensure timely reporting of critical finding for PC3 episodes of care. It also needs to hold TriWest accountable for meeting contract performance standards and for delaying the treatment of potentially life-threatening illnesses.

Conclusion

TriWest is not providing critical findings to VA within specific time frames stipulated in the PC3 contract. We identified three critical findings. However, TriWest reported only one of the three critical findings in its monthly reports to VA. VA was also responsible for delays in these three veterans' critical care, as well as the untimely reporting of critical findings by TriWest. Until VA establishes an effective follow-up process to ensure timely reporting of critical findings for PC3 episodes of care and holds TriWest accountable to meet contractual obligations, VA will lack the ability to deliver timely continuity of care when our veterans need it most.

Recommendations

6. We recommended the Under Secretary for Health ensure that Patient-Centered Community Care contractors annotate on all diagnostic imaging reports and non-imaging-related critical findings submitted to VA the name of the VA person contacted, and the date and time of the contact.

7. We recommended the Under Secretary for Health implement procedures to verify whether Patient-Centered Community Care contractors and their network providers correctly and timely report critical findings to VA and impose financial penalties or other remedies when contractors fall below the contract performance threshold.

Agency Comments

The Under Secretary for Health concurred with our findings and recommendations and stated that VHA would implement Recommendation 6 by February 2016, and Recommendation 7 by April 2016. The Under Secretary for Health's entire verbatim response is located in Appendix D.

OIG Response

The Under Secretary for Health's planned corrective actions are acceptable. We will monitor VHA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

Appendix A Scope and Methodology

Scope

This is one of a series of five reports addressing PC3 service delivery and contract issues issued in fiscal year 2015. We conducted our review work from November 2014 through May 2015. The review focused on the population of disbursed PC3 payments from January 1, 2014, through September 30, 2014. We reviewed both outpatient and inpatient pre-authorized care including specific acute Current Procedural Terminology (CPT) codes associated with biopsies performed during gastroenterology procedures and radiology CPT codes for breast mammography and Positron Emission Tomography (PET) scans.

Methodology

For each sampled item, we obtained access and searched the PC3 contractor portals for clinical documentation specific to the CPT codes associated with those listed on the payment invoices. If any of the documentation was missing, we considered it to be incomplete. For example, a gastroenterology procedure where a specimen was removed would be an incomplete documentation error if the pathology and/or the procedure report were not provided. For the documentation that was complete, we recorded the date that it was made available to VA on the PC3 contractor portal. We determined the last date of the outpatient episode of care to measure against the date that the documentation was made available to VA. We then compared this number with the contract standard of 14 calendar days for outpatient procedures or 30 business days for inpatient procedures.

For each sample item, we reviewed the clinical documentation obtained from the contractor portal as well as the Electronic Health Records (EHR) to identify any critical findings. We used the definitions in the contract to determine critical findings. For each identified critical finding, we examined whether they were reported by the contractor in their monthly report to the PC3 program office. Additionally, if a critical finding was identified, we determined whether the contractor notified VA within the time specified in the contract, and annotated the clinical documentation to indicate the details of the report of the critical finding to VA. We also examined the veteran's EHR for documentation of the critical finding within VA records. We then provided the critical findings to OIG Office of Healthcare Inspectors to review and confirm the seriousness of the three critical findings.

Data Reliability

We obtained computer-processed data from VHA's Central Fee File to perform a sample of paid PC3 invoices for the purpose of our review. To test the reliability of these data, we compared key fields in the Central Fee File records with 40 invoices from 6 VA medical facilities. Our testing of the VHA data disclosed that the data were sufficiently reliable for our review objectives.

VA lacked an independent source of data to verify contractor compliance. In addition to the Central Fee File, further episode of care information was sought from PC3 contractor systems at Health Net and TriWest to conduct our review. We subsequently tested the data reliability of the documentation obtained from the contractor systems and were unable to sufficiently validate PC3 contractor documentation against VA documentation. As such, the data cannot be stated as sufficiently reliable. As a result, we explained the condition and made a recommendation that VA implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix B Statistical Sampling Methodology

To determine whether PC3 contractors are providing timely clinical documentation and appropriate notification of critical findings, we sampled paid invoices for Health Net and TriWest from January 1, 2014, through September 30, 2014.

Population

We identified 20,790 paid invoices that resulted in approximately $3.8 million dollars of PC3 expenditures for the period of January 1, 2014, through September 30, 2014, for both outpatient and inpatient care.

Sampling Design

We divided our population into 10 strata for both PC3 contractors, Health Net and TriWest. We stratified the universe to isolate higher risk procedures as well as outpatient and inpatient care. The strata are the result of dividing the population into five categories of care, one for each contractor: Inpatient Care, Gastroenterology, PET, Mammography, and all remaining procedures. We isolated each stratum by specific CPT codes identified in Tables 4 and 5.

Table 4. PC3 Sample Size by Stratum for Health Net

Stratum	Description	PC3 Contractor	Sample	Population
1	Inpatient Care—All CPT Codes	Health Net	1	1
3	Gastroenterology—CPT Codes: 45380, 43239	Health Net	80	80
5	PET—CPT Codes: 78815, 78816, 78802	Health Net	30	204
7	Mammography—CPT Codes: G020 G0204, G0206	Health Net	30	210
9	All Remaining CPT Codes	Health Net	30	7,512
	Total for Health Net		**171**	**8,007**

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Table 5. PC3 Sample Size by Stratum for TriWest

Stratum	Description	PC3 Contractor	Sample	Population
2	Inpatient Care—All CPT Codes	TriWest	30	30
4	Gastroenterology—CPT Codes: 45380, 43239	TriWest	159	159
6	PET—CPT Codes: 78815, 78816, 78802	TriWest	13	13
8	Mammography—CPT Codes: G0202, G0204, G0206	TriWest	30	54
10	All Remaining CPT Codes	TriWest	30	12,520
	Total for TriWest		**262**	**12,776**
	Total for Both PC3 Contractors		**433**	**20,783**

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Lastly, we performed a simple random sample of five strata and reviewed all items in the remaining stratum. This resulted in a sample of 433 payment invoices for the purpose of our review. We designed the sampling plan to ensure we had a chance to select from all PC3 invoices that were paid during the period of January 1, 2014, through September 30, 2014, and allowed for making a projection over the entire population.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

We used a 90 percent confidence interval for our projections. The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this review with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time. Tables 6, 7, 8 and 9 show the error rates and estimates based on our analysis of sample items.

Table 6. Estimated PC3 Clinical Documentation Timeliness

PC3 Contractor	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net				
Late Documents	4,965	1,141	3,824	6,107
Incomplete Documents	23	16	7	39
Compliant Documents	3,019	1,141	1,877	4,160
TriWest				
Late Documents	4,946	1,844	3,102	6,790
Incomplete Documents	4,161	1,769	2,391	5,930
Compliant Documents	3,669	1,718	1,951	5,387
Weighted Estimate for Both Contractors				
Late Documents	9,911	2,168	7,743	12,080
Incomplete Documents	4,184	1,769	2,414	5,953
Compliant Documents	6,688	2,063	4,626	8,751

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Table 7. Estimated PC3 Clinical Documentation Timeliness (percent error)

PC3 Contractor	Estimated Error	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net				
Late Documents	62.0 percent	14.3 percent	47.8 percent	76.3 percent
Incomplete Documents	0.3 percent	0.2 percent	0.1 percent	0.5 percent
Compliant Documents	37.7 percent	14.3 percent	23.4 percent	52.0 percent
TriWest				
Late Documents	38.7 percent	14.4 percent	24.3 percent	53.1 percent
Incomplete Documents	32.6 percent	13.8 percent	18.7 percent	46.4 percent
Compliant Documents	28.7 percent	13.4 percent	15.3 percent	42.2 percent
Weighted Estimate for Both Contractors				
Late Documents	47.7 percent	10.4 percent	37.3 percent	58.1 percent
Incomplete Documents	20.1 percent	8.5 percent	11.6 percent	28.6 percent
Compliant Documents	32.2 percent	9.9 percent	22.3 percent	42.1 percent

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Table 8. Estimated Days to Return Complete Documentation by Contractor (Days)

Complete Documentation	Estimated Days To Return	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Outpatient				
Health Net	68.8	21.7	47.1	90.5
TriWest	21.7	8.1	13.6	29.8
Weighted Estimate for Both Contractors	44.4	11.5	32.9	55.9
Inpatient				
Health Net	6.0	-	-	-
TriWest	46.0	-	-	-
Weighted Estimate for Both Contractors	44.4	-	-	-

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Note: Because we reviewed all 31 inpatient encounters, the average number of days to return documentation was not an estimate, and therefore there was no margin of error.

Table 9. Estimated Improper Payment by Contractor

PC3 Contractors	Estimated Improper Payment	Margin of Error	Confidence Interval Lower Limit 90%	Confidence Interval Upper Limit 90%
Health Net	$5,442	$1,536	$3,906	$6,978
TriWest	$864,707	$423,085	$441,622	$1,287,791
Weighted Estimate for Both Contractors	$870,149	$423,088	$447,061	$1,293,236

Source: VA OIG analysis of clinical documentation provided by PC3 contractors

Appendix C Potential Monetary Benefits in Accordance With Inspector General Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1, 4	Improper payments that consist of payments made without proper support; that is, without proper medical documentation, and statistically projected for the sample period from January through September 2014.		$870,149
	Avoidance of improper payments that consist of payments made without proper support; that is, without proper medical documentation, for the remainder of the PC3 contract up to 4 option years (from October 2014 through September 2018 by implementing our recommendations. See note below for calculation.		$4,640,796
	Did not properly assess disincentive penalties for contractors' lack of performance.	$257,652	
	Total	**$257,652**	**$5,510,945**

Note: The PC3 contract is in its first of 4 option years. The period of our review was January 1, 2014, through September 30, 2014, during the base contract year. Questioned costs were calculated by identifying improper payments made during 3 quarters of the base year ($870,149) and adding a 4th quarter amount of about $290,050 ($870,149/3) for a total of $1,160,199 for fiscal year 2014 improper payments. Disincentive penalties were made by multiplying the estimated $15,156 penalty assessed during 1 quarter of the base year by four for a total of $60,624. The yearly amount of $60,624 was then multiplied by the 4 option years plus the estimated amount from that base year for a total of $257,652. If VA does not correct issues identified in this report and does implement the remaining four option years the total additional improper payments can potentially be $4,640,796 ($1,160,199 x 4) and $242,496 ($60,624 x 4) in missed assessed penalties.

Appendix D Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 9, 2015

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Patient-Centered Community Care (PC3) Health Record Coordination (VAIQ 7636549)

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

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Veterans Health Administration's corrective action plan for recommendations 1 through 7.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

(original signed by:)

David J. Shulkin, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Review of Patient-Centered Community Care (PC3) Health Record Coordination

Date of Draft Report: August 18, 2015

Recommendations/ Actions	Status	Target Completion Date

Recommendation 1. We recommended the Under Secretary for Health implement a mechanism to ensure payments are not made to Patient-Centered Community Care contractors until all required clinical documentation is received.

VHA Comments: Concur.

The Veterans Health Administration's (VHA) Chief Business Office Purchased Care (CBOPC) understands the importance Patient-Centered Community Care (PC3) clinical documentation holds in maintaining a continuum of care for Veterans, as well as the PC3 contract requirements for confirming clinical documentation receipt prior to issuing payment; however, implementing a step to review for clinical documentation receipt during payment processing would have an immediate, detrimental impact to overall program operations. Due to the high rate of non-compliance, a significant number of claims would have to be processed more than once, leading to an exponential increase in overall claims volume without sufficient resources to address the increased workload. Further work must also be done to identify what records comprise the required clinical documentation for an episode of care to properly train staff to execute this process. To address this finding, CBOPC will analyze current processes and request the additional resources needed to avoid impeding payment processing activity and subsequent claims processing timeliness and penalties. CBOPC will also review existing guidance on required clinical documentation for various episodes of care and make necessary updates. Once new resources are in place, identified staff will be trained to verify clinical documentation receipt as part of the payment process and corresponding process oversight activates incorporated into PC3 internal controls.

To complete this action plan, VHA will submit:

- Dissemination of the process to staff (e.g., Standard operating procedure, blast email, national call).
- Sample report showing outcome of process oversight activities.

Status:	Target Completion Date:
In process	August 2016

Page 2.

Review of Patient-Centered Community Care (PC3) Health Record Coordination

Recommendation 2. We recommended the Under Secretary for Health enforce Patient-Centered Community Care contract performance requirements to ensure that contractors return complete clinical documentation timely.

VHA Comments: Concur.

VHA CBOPC currently monitors PC3 contractor performance on a monthly basis for compliance with the contract performance requirement to return complete clinical documentation timely. This is also one of the reporting measurements weighted when determining incentives/disincentives. For PC3 contractors who are not meeting the timeliness standard, Corrective Action Letters have been issued by the contracting officer requiring the contractors to submit corrective action plans. Upon review and acceptance of contractors' corrective action plans, PC3 contracting officer representatives (COR) are monitoring corrective actions through to satisfactory completion.

To complete this action, VHA will provide the following documentation:

- 6-month analysis of monitoring data.
- Contractors' Action Plans.
- Examples of PC3 contractors' corrective action plans.
- Evidence of corrective action monitoring for those PC3 contractors required to take corrective actions.

Status:	Target Completion Date:
In process	April 2016

Recommendation 3. We recommended the Under Secretary for Health implement a mechanism to verify contractors' performance without relying on contractors' self-reported data.

VHA Comments: Concur.

It is important to receive the contractors' self-reported data for purposes of contract performance, however VHA concurs that it is important to have processes in place to validate the contractors' reported data against VA internal data. VHA CBOPC will identify all self-reported data from the PC3 contractors and how the data is used across the program and to evaluate contractor performance. An interdisciplinary workgroup will then analyze the information and develop recommendations for next steps to reduce reliance on the PC3 contractors' self-reported data and identify alternative ways to verify contractors' performance.

Page 3.

Review of Patient-Centered Community Care (PC3) Health Record Coordination

To complete this action, VHA will provide the following documentation:

- Next steps for reducing reliance on self-reported data in verifying contractor performance

Status:	Target Completion Date:
In process	February 2016

Recommendation 4. We recommended the Under Secretary for Health complete a review of TriWest's performance and apply penalties if it is determined there is a lack of performance related to the timely return of clinical documentation.

VHA Comments: Concur.

As medical documentation is one of the four performance measures used to calculate incentives and disincentives, penalties are already being imposed on the contractors when their performance is less than the contractual requirement. On September 11, 2015, VHA will conduct a PC3 Program Management Review. Based on the assessments completed in preparation for this review, VHA will recommend TriWest be placed on a corrective action plan. PC3 contracting officer representatives will monitor TriWest's progress in completing the performance improvement plan and coordinate with the contracting officer for actions to be taken if TriWest is unable to satisfactorily comply with the corrective action plan.

To complete this action, VHA will provide the following documentation:

- Copy of corrective action plan.
- 6-month analysis of monitoring data.
- Evidence of corrective action monitoring.

Status:	Target Completion Date:
In process	February 2016

Recommendation 5. We recommended the Under Secretary for Health review the contract disincentives applied to Healthnet and determine if additional funds need to be recouped from the contractor and pursue collection if disincentives were under applied.

VHA Comments: Concur.

Page 4.

Review of Patient-Centered Community Care (PC3) Health Record Coordination

Medical documentation return is one of four measurements used in incentive and disincentive calculations. VHA CBOPC will work with the PC3 contracting officer and the Denver Acquisition and Logistics Center to review of all performance management activities taken to date regarding Healthnet's performance under the PC3 contract. Based on that assessment and consideration of all four measurements, the contracting officer will determine if additional actions are warranted and take necessary steps to execute as appropriate.

To complete this action, VHA will provide the following documentation:

- Summary assessment of Healthnet's performance as compared to performance management activities taken to date and next steps.
- Examples of contractor's corrective action plans if required.
- Evidence of performance improvement monitoring if Healthnet is required to take corrective actions.

Status:	Target Completion Date:
In process	February 2016

Recommendation 6. We recommended the Under Secretary for Health ensure that Patient-Centered Community Care contractors annotate on all diagnostic imaging reports and non-imaging related critical findings submitted to VA the name of the VA person contacted, and the date and time of the contact.

VHA Comments: Concur.

VHA CBOPC takes matters related to patient safety very seriously. The process for timely reporting and documentation of critical findings identified by non-VA providers is a performance monitor in the PC3 contract. Monthly performance reviews are conducted to verify contractor performance and while systemic issues have not been identified, it has become clear that a renewed effort is necessary to tighten and improve the critical finding reporting process overall. CBOPC will form a workgroup charged with reviewing the current process, identifying opportunities for improvement, and assessing whether additional contract requirements are desired. An action plan will be developed based on the workgroup's efforts.

Review of Patient-Centered Community Care (PC3) Health Record Coordination

To complete this action, VHA will provide the following documentation:

- Action plan capturing workgroup's recommendations and next steps for execution of action plan.

Page 5.

Review of Patient-Centered Community Care (PC3) Health Record Coordination

Status:	Target Completion Date:
In process	February 2016

Recommendation 7. We recommended the Under Secretary for Health implement procedures to verify whether Patient-Centered Community Care contractors and their network providers correctly and timely report critical findings to VA and impose financial penalties or other remedies when contractors fall below the contract performance threshold.

VHA Comments: Concur.

VHA CBOPC currently monitors the PC3 contractors' timeliness in reporting critical findings. For PC3 contractors who do not meet the required performance standard, "Letters of Corrections" will be issued that require the contractor to submit a corrective action plan. Upon review and acceptance of contractors' corrective action plans, PC3 contracting officer representatives will monitor corrective actions through to satisfactory completion.

To complete this action, VHA will provide the following documentation:

- 6-month analysis of monitoring data.
- Contractors' Action Plans.
- Examples of PC3 contractors' corrective action plans.
- Evidence of performance improvement monitoring for those PC3 contractors required to take corrective actions.

Status:	Target Completion Date:
In process	April 2016

Veterans Health Administration
September 2015

Appendix E Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Matthew Rutter, Director Jill Akridge Andrea Buck, MD Sophia Demco Chris Enders Lee Giesbrecht Todd Groothuis Michael Kelly Issa Ndiaye Steven Toom

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