United States Government Accountability Office

Report to Congressional Requesters

November 2022

VETERANS COMMUNITY CARE PROGRAM

VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers

GAO-23-105290

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GAO Highlights

Highlights of GAO-23-105290, a report to congressional requesters

Why GAO Did This Study

Under the Veterans Community Care Program, VA's two Community Care Network contractors are responsible for maintaining provider networks that are adequate in size and have the capacity to ensure veterans' timely access to care.

GAO was asked to review VA's Community Care Networks. This report, for Community Care Network Regions 1-4, (1) describes how VA monitors contractor compliance with network adequacy standards and related requirements; (2) examines the extent to which VA's contractors are meeting network adequacy standards; and (3) examines the experiences of VA medical facility officials when scheduling routine appointments for veterans.

GAO reviewed documentation, such as the Community Care Network contracts, and network adequacy performance data and assessed VA's relevant processes. GAO conducted a survey of VA medical facility officials in Regions 1-4, and conducted covert calls to a non-generalizable sample of community providers. GAO also interviewed VA officials and contractor representatives.

What GAO Recommends

In addition to reiterating prior recommendations related to staffing and fraud risks, GAO is making two new recommendations to VA: (1) ensure that contractors report complete performance data and (2) implement strategies to increase the accuracy of community provider information. VA concurred with the recommendations and identified steps it would take to implement them.

View GAO-23-105290. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov.

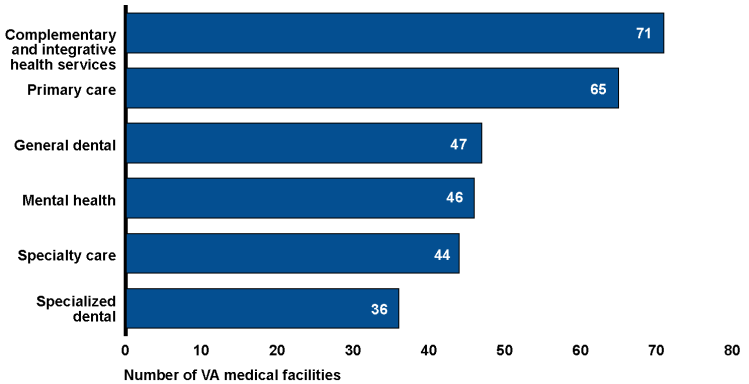
What GAO Found

The Department of Veterans Affairs (VA) utilizes two contractors to manage its regional networks of community providers, called Community Care Networks, to deliver care to veterans under the Veterans Community Care Program. VA requires its contractors to meet two network adequacy standards that specify maximum drive-time distances and wait times for appointments.

VA monitors contractor compliance with network adequacy requirements by reviewing the contractors' analysis of claims data against the standards. VA officials determined the contractors generally met the standards for the period from April 2020 to May 2022. However, GAO found that VA's assessment was based on incomplete data, as the contractors did not include all claims. Further, VA was unaware of this, as it lacked a mechanism to ensure the contractors submitted complete data, limiting VA's performance assessment for Regions 1-4.

GAO's analysis of VA officials' responses from 127 of 138 VA medical facilities, and undercover calls to 80 community providers in Community Care Network Regions 1-4, revealed potential challenges with scheduling appointments. Specifically, officials cited challenges scheduling with certain types of providers within VA's routine appointment availability standard (care not deemed urgent or emergent by a VA provider). (See fig. below.) Responding officials noted concerns with insufficient VA facility staff to schedule appointments, and inaccurate provider information in VA's provider directory, including providers no longer participating in the network (also confirmed through GAO's undercover calls). These issues can delay appointment scheduling. GAO previously reported on these issues, and recommended in 2020 and 2021 that VA (1) direct its medical facilities to assess community care staffing and (2) improve controls to address risks related to inaccurate provider addresses, respectively. VA has taken some actions, but has not yet implemented these recommendations.

Number of VA Medical Facilities Reporting More than Half of Routine Appointments Scheduled within 30 Days by Care Type, April 2022



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

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Abbreviations

CCN	Community Care Network
CIHS	complementary and integrative health services
PPMS	Provider Profile Management System
VA	Department of Veterans Affairs
VCCP	Veterans Community Care Program

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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November 10, 2022

Congressional Requesters

The Department of Veterans Affairs (VA) implemented the Veterans Community Care Program (VCCP) on June 6, 2019, as required under the VA MISSION Act of 2018.[1] The VA MISSION Act aimed to strengthen and improve VA's health care system for veterans and their caregivers, and required, among other things, VA to implement a permanent community care program. This program allows eligible veterans to receive care from community providers when they face certain challenges accessing care at VA medical facilities.[2] The VA MISSION Act also assigned VA responsibility for ensuring that veterans' VCCP appointments are scheduled in a timely manner.

Under the VCCP, VA established five regional networks of community providers, known as Community Care Networks (CCN), to deliver health care services to veterans. VA oversees two contractors—Optum Public Sector Solutions and TriWest Healthcare Alliance—that are responsible for maintaining the five CCN provider networks, known as CCN Regions 1-5, and ensuring they are adequate in size, scope, and capacity to ensure veterans receive timely access to care. Under the CCN contracts, the contractors are required to meet two primary standards VA established to ensure network adequacy in Regions 1-4; these standards specify maximum distances veterans may drive to community providers, and maximum wait times for appointments.[3]

Since its implementation in 2019, we have issued a number of reports reviewing the VCCP and VA's management of the program, including the

[1]Pub. L. No. 115-182, 132 Stat. 1393 (2018).

[2]VA has allowed eligible veterans to receive community care through various programs since 1945.

[3]We did not include Region 5, Alaska, in our review as the drive-time and appointment availability standards are different from those found in Regions 1-4.

CCNs.[4] The CCNs are vital to the success of the VCCP, as they are the main vehicle through which VA provides community care. You asked us to review VA's implementation of the VCCP including whether VA medical facilities have the resources needed to manage the program. In this report, we

1. describe how VA monitors contractor compliance with network adequacy standards and related requirements for CCN Regions 1-4;
2. examine the extent to which VA's contractors are meeting network adequacy standards in CCN Regions 1-4; and
3. examine VA medical facility officials' experiences scheduling routine appointments for veterans in CCN Regions 1-4.

To address the first objective, we reviewed VA's CCN contracts to identify applicable network adequacy standards and requirements, and we also reviewed any relevant standard operating procedures related to monitoring network adequacy. We interviewed officials from VA's Office of Integrated Veteran Care, the VA office responsible for oversight of the VCCP, and representatives from the two contractors—Optum and TriWest—about the network adequacy standards and the requirements in place for monitoring network adequacy in CCN Regions 1-4.

To address the second objective, we reviewed VA's CCN contracts and contractor-submitted documents, including network adequacy performance reports, corrective action plans, and contractor requests for deviations from the network adequacy standards. We analyzed network

[4]See GAO, *Veterans Community Care Program: Improvements Needed to Help Ensure Timely Access to Care,* GAO-20-643 (Washington, D.C.: Sept. 28, 2020); *Veterans Community Care Program: Immediate Actions Needed to Ensure Health Providers Associated with Poor Quality Care Are Excluded,* GAO-21-71 (Washington, D.C.: Feb. 1, 2021); *Veterans Community Care Program: VA Took Action on Veterans' Access to Care, but COVID-19 Highlighted Continued Scheduling Challenges,* GAO-21-476 (Washington, D.C.: June 28, 2021; and *Veterans Community Care Program: VA Should Strengthen Its Ability to Identify Ineligible Health Care Providers,* GAO-22-103850 (Washington, D.C.: Dec 17, 2021).

In addition, VA health care was added to our High Risk List in 2015 and has remained on it including the most recent publication in March 2021. GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021).

adequacy performance data for drive time and appointment availability submitted by the CCN contractors in Regions 1-4 from May 2020 through April 2022, the most recent data available. We reviewed the data to identify any obvious errors, and interviewed VA officials and contractor representatives about the data. On this basis, we determined these data were sufficiently reliable for the purpose of our audit objective. We assessed the extent to which VA processes ensured that the contractors submitted performance data as required against requirements found in the CCN contracts and against federal internal control standards for information and monitoring.[5] See appendix I for more details on our scope and methodology.

To address the third objective, we conducted a survey between February 28, 2022, and April 22, 2022, of VA medical facility officials who oversee the VCCP across all 138 VA medical facilities for which the contractors report network adequacy performance data in Regions 1-4. We analyzed the responses from the 127 VA medical facilities that responded to our survey.[6] In addition, VA provided us with a list of general dentists and gastroenterologists in CCN Regions 1-4 from its Provider Profile Management System (PPMS), VA's master database of community providers.[7] We selected a non-generalizable sample from that list to conduct 80 covert tests (i.e. undercover calls) in March 2022 to assess the extent of appointment availability with those providers. We also assessed the PPMS data we received, including provider addresses and phone numbers, against federal internal control standards for information to determine whether PPMS information was reasonably free from error and represented providers participating in the CCN as of March 2022.[8] See appendix I for more details on our scope and methodology.

[5]Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: Sept. 10, 2014).

[6]Of the 138 VA medical facilities we contacted, 135 were VA health care systems or VA medical centers, one was a Multi-Specialty Community-Based Outpatient Center, one was an outpatient clinic, and one was a federal healthcare facility that combines VA and Department of Defense medical care in one facility.

[7]We selected these two provider types based on a number of criteria, including network adequacy performance data, deviation request data, and interviews with VA officials and contractor representatives.

[8]See GAO-14-704G.

We conducted this performance audit from June 2021 to November 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

Veterans Community Care Program

VA established the VCCP in June 2019, which consolidated and replaced VA's previous community care programs into a permanent program aimed at providing health care to eligible veterans when providers at VA medical facilities could not reasonably deliver care.[9] For example, eligible veterans may choose to receive care under the VCCP when services are not available at a VA medical facility.[10] According to VA, approximately 2 million veterans received community care in fiscal year 2021.

[9]The VA MISSION Act required VA to implement within 1 year of the law's enactment a permanent community care program. Pub. L. No. 115-182, tit. I, § 101,132 Stat. 1393, 1395-1404 (2018).

[10]Under the VCCP, veterans are eligible for community care when (1) VA does not offer the care or service required by the veteran; (2) the veteran resides in a state without a full-service VA medical facility; (3) the veteran would have been eligible under the 40-mile criterion of the Veterans Choice Program before June 6, 2018; (4) VA cannot provide the veteran with care and services that comply with its designated access standards; or (5) the veteran and the veteran's referring clinician agree that it is in the best interest of the veteran to receive care in the community. Further, VA may authorize community care when VA determines that it is not providing certain care that complies with its quality standards. In addition to this criteria, veterans must either be enrolled in VA health care or eligible for VA care without needing to enroll, and in most circumstances, veterans must receive approval from VA prior to obtaining care from a community provider. See Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395-1404 (2018), codified at 38 U.S.C. § 1703(d), (e), and implementing regulations at 38 C.F.R. §§ 17.4000 - 17.4040.

VA's Provider Profile Management System

The Provider Profile Management System (PPMS) is VA's master database of community providers, including Community Care Network (CCN) providers, that was deployed at the end of fiscal year 2018. The system receives and stores information from multiple sources, such as the CCN contractors, about each provider. This information includes demographic information and the types of services the provider is authorized to deliver.

Source: GAO analysis of Department of Veterans Affairs (VA) documentation. | GAO-23-105290

VA's Office of Integrated Veteran Care manages the VCCP at the national level, while VA medical facility community care staff coordinate veterans' care with community providers at the local level.[11] As described in VA guidance, when scheduling community care appointments on behalf of veterans, VA medical facility community care staff take several actions to review the veteran's referral for care and schedule the appointment.[12] This process includes (1) gathering any veteran scheduling preferences; (2) identifying and contacting community providers listed in PPMS—VA's database of community providers (see sidebar)—to determine appointment availability; (3) creating and sending the veteran's referral information to the community provider; (4) scheduling the veteran's appointment with the provider; (5) and communicating appointment details to the veteran.

Community Care Networks

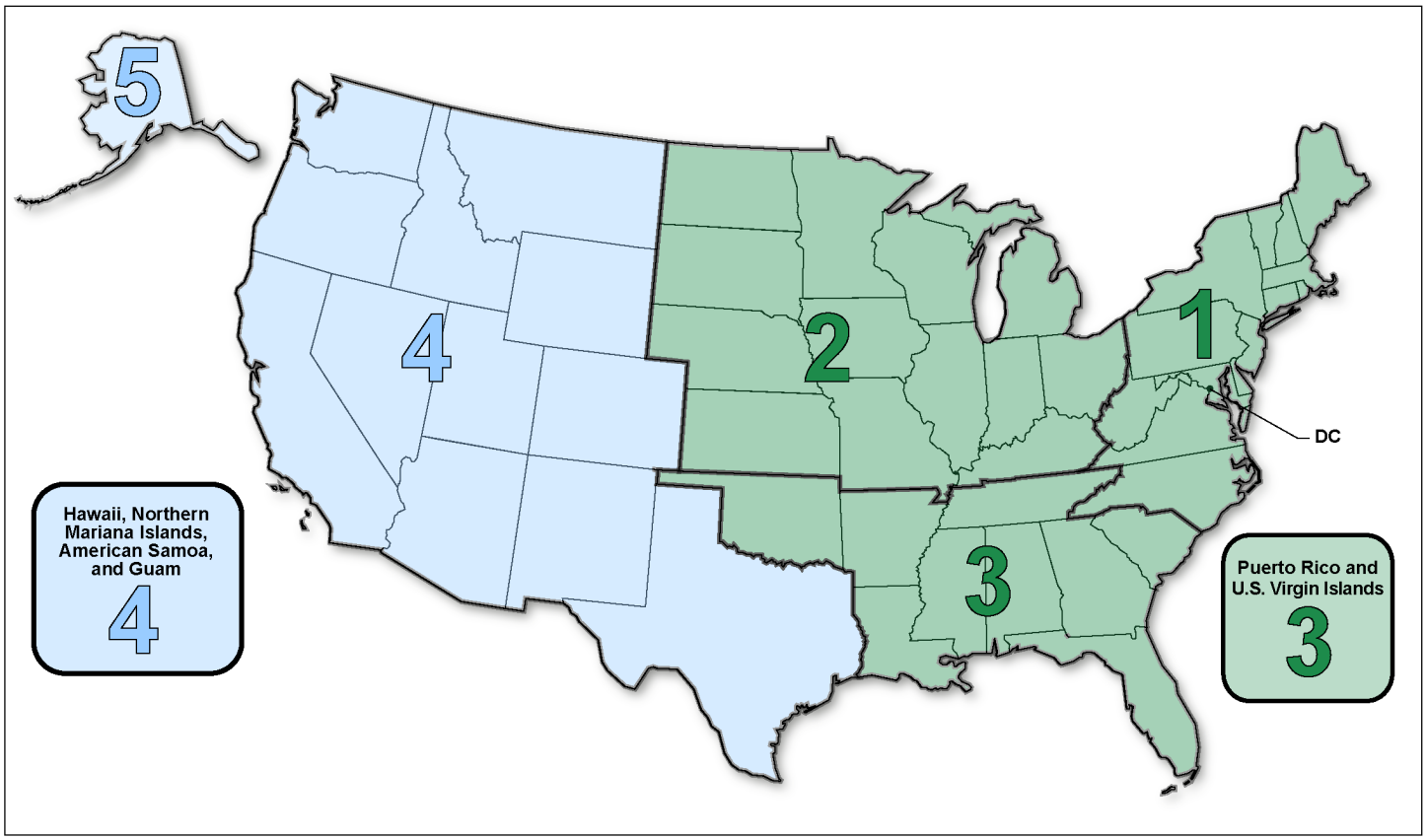
VA primarily purchases community care under the VCCP through five regional contracts called CCNs. VA contracted with Optum and TriWest to develop and administer the CCNs.[13] Optum administers CCN Regions 1-3, and TriWest administers Region 4. TriWest also administers Region 5, but it is outside the scope of our review due to different network adequacy standards. (See fig. 1.)

[11]In May 2022, VA's Office of Community Care and Office of Veterans Access to Care combined to form the Office of Integrated Veteran Care.

[12]In addition to VA medical staff scheduling on behalf of veterans, some VA medical facilities exercise a contract option to receive CCN contractor support in scheduling appointments. In some cases, veterans may also directly schedule appointments with providers.

[13]VA can also purchase care for eligible veterans through Veterans Care Agreements—direct agreements with community providers for services not provided through the CCN contracts—and through sharing agreements with other federal agencies, such as the Department of Defense.

Figure 1: Map of Community Care Network Regions and Contractors



Source: GAO analysis of Department of Veterans Affairs (VA) information (data); Map Resources (map). | GAO-23-105290

Note: The awarded contractors are Optum Public Sector Solutions (Optum) and TriWest Healthcare Alliance (TriWest).

VA implemented the CCN contracts in a phased approach by VA medical facility across the regions, beginning with VA medical facilities in CCN Region 1:

- Region 1 was fully implemented in December 2019;
- Region 2 was fully implemented in March 2020;
- Region 3 was fully implemented in June 2020; and

- Region 4 was fully implemented in August 2020.[14]

The two contractors are responsible for establishing and maintaining networks of licensed health care community providers and practitioners, including hospitals, physician group practices, and individual physicians, and paying community provider claims. Services provided under the CCN include

- medical services, which cover primary care and specialty care, with specialty care consisting of services such as mental health, cardiology, and gastroenterology;
- complementary and integrative health services (CIHS), such as biofeedback, massage therapy, Native American healing, and relaxation techniques; and
- dental services (for eligible veterans), which comprise both general dental (e.g., exams, cleanings) and specialized dental (e.g., endodontics, periodontics).[15]

Once a provider is added to the network, the contractors are also responsible for supplying VA with demographic data on that provider, and any subsequent updates to that provider's information. These data populate PPMS, which VA medical facility staff use to locate providers when scheduling community appointments.

Network Adequacy Standards

The CCN contracts also require the contractors to maintain provider networks that are adequate in size, scope, and capacity to ensure that veterans receive timely access to care. To help ensure this, VA requires its contractors to meet two network adequacy standards. These standards establish maximum drive times to CCN providers and maximum appointment availability wait times—the maximum amount of time veterans should have to wait to obtain their appointments. The two

[14]Region 5 was fully implemented in June 2021.

[15]The CCN contracts provide for other services, like pharmacy services, which we determined are outside the scope of our review—see appendix I for more information on our methodology. See 38 U.S.C. §§ 1710(c) and 1712 and 38 C.F.R. §§ 17.93 and 17.160-17.166 for dental eligibility requirements and benefits. VA used the term "general care" in the first contracts for Regions 1-3 to cover specialty care services, and as a lesson learned, changed the term to "specialty care" when awarding the Region 4 contract. VA officials stated they executed a contract modification for Regions 1-3 to update this category to "specialty care" across all Regions. Therefore, we use the term specialty care in this report.

standards vary by factors such as care type and veteran geographic location.[16] (See table 1.)

Table 1: Selected Network Adequacy Standards as of August 2022, CCN Regions 1-4

	Maximum drive times			Maximum appointment availability wait times
Location of veteran	**Primary care**	**General dental**	**Specialty care/ Specialized dental/CIHS**	**Routine care**
Urban	30 minutes	30 minutes	45 minutes	30 days
Rural and highly rural	45 minutes	45 minutes	100 minutes	30 days

Source: GAO analysis of the Community Care Network (CCN) contracts for Regions 1-4. | GAO-23-105290

Notes: The Department of Veterans Affairs (VA) uses two contractors to administer networks of providers, known as CCNs, to deliver care to veterans in the community. The first contracts for the CCNs awarded in fiscal year 2019 included different drive-time standards for highly rural veterans—60 minutes for primary care, 90 minutes for general dental, and 180 minutes for specialty care, specialized dental, and complementary and integrative health services (CIHS). According to VA officials, VA changed the standards in order to increase access to care. General dental includes services such as exams and cleanings; specialized dental includes services such as endodontics; and CIHS includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care needed by the veteran that is not considered emergent or urgent, encompassing all care types.

- VA's drive-time standard depends on the veteran's location and care referral type. Drive times are calculated from the veteran's home address on record with VA to the provider's address.[17]
- VA's appointment availability standard depends on the urgency of the needed care (regardless of care type). The maximum appointment availability time for routine care (that is, care not considered emergent) is 30 days, calculated from the date VA sends the referral

[16]The first CCN contracts awarded in fiscal year 2019 had different drive-time standards for claims for highly rural veterans—60 minutes for primary care, 90 minutes for general dental, and 180 minutes for specialty care, specialized dental, and CIHS. Appointment availability also varies by urgency of care, and the contracts include standards for urgent and emergent care, which are outside the scope of our review because they generally do not require scheduled appointments.

[17]Drive times are calculated using mapping software and do not factor in traffic conditions between the two addresses.

to the contractor to the date the veteran receives care, using claims and referral data.[18]

- Even with these defined standards, veterans still have the option to use their "veterans' preference" to choose providers outside the maximum drive times or schedule appointments to occur beyond the 30 days.

At the time of contract award, Regions 1-4 had different drive-time standards for highly rural veterans—60 minutes for primary care, 90 minutes for general dental, and 180 minutes for specialty care, specialized dental, and CIHS as compared to the standards for rural veterans shown in the table above.[19] VA officials stated that they began negotiating contract modifications in September 2019 with the contractors to combine the rural and highly rural drive-time standards (to reflect the rural standards) in order to increase access to care for veterans residing in highly rural areas. This modification was implemented in Regions 1-3 in June 2022, and Region 4 in August 2022.

VA Monitors Contractor Compliance with Network Adequacy Requirements through Contractor-Provided Documentation and Monthly Meetings

VA monitors contractor compliance with network adequacy requirements found in the CCN contracts for Regions 1-4 by reviewing documentation submitted by the two contractors—Optum and TriWest—and by meeting regularly with contractor staff. Contractor-provided documents reviewed by VA to assess contractor network adequacy include (1) network adequacy performance reports and (2) corrective action plans. The CCN contracts also include a requirement for the contractors to calculate a regional performance score. In August 2022, VA officials stated they will begin measuring contractor compliance with the regional performance score requirement in fall 2022.

Network adequacy performance reports. The CCN contracts require the contractors to submit network adequacy performance reports to VA on a regular basis that show each contractor's performance against VA's

[18]This standard does not include the time it takes VA to process the referral before sending to the contractors. VA also defined appointment availability standards for emergent and urgent care—24 hours and 48 hours, respectively. Emergent and urgent care are outside the scope of our review.

[19]According to the CCN contract, a highly rural location is defined as a sparsely populated area located in a county with fewer than seven individuals residing in that county per square mile.

network adequacy standards.[20] To develop these reports, the contractors calculate the percentage of adjudicated (paid) claims from the previous month that met VA's drive-time and appointment availability standards, and submit these data in spreadsheets to VA. The performance reports for drive-time standards are based on claims data for each service type measured independently by rurality per VA medical facility.[21] The performance reports for appointment availability are based on claims data for each service type measured independently by urgency per referral originating from a VA medical facility.[22] (See fig. 2 for example performance report templates.) See appendix III for more information on network adequacy performance reports, and the data used for them that has been reported by the contractors.

[20]The contracts for Regions 1-3 require the network adequacy performance reports to be submitted to VA monthly, while the Region 4 contract requires submission on a quarterly basis. TriWest representatives stated that while they submit the reports quarterly to VA, they create and review the reports internally on a monthly basis. They also discuss these reports on a monthly basis when meeting with VA facility staff.

[21]According to VA officials, the contractors measure network adequacy performance for the claim for the first appointment associated with a veteran's referral against both standards. Officials explained that a referral can be associated with multiple appointments, resulting in multiple claims.

[22]VA officials confirmed that while the claims may be adjudicated in a specific month, the date the care took place may not coincide with the month in which the claim was adjudicated. VA allows community providers up to 180 days to file claims for rendered services to the CCN contractors for payment.

Figure 2: Example CCN Network Adequacy Performance Report Template for Drive Time and Appointment Availability

EXAMPLE DRIVE-TIME PERFORMANCE REPORT TEMPLATE

Reporting month	Service type	Rurality	Facility	Number of claims	Average drive time (minutes)	Average distance (miles)	Deviations	Percentage of claims that met VA's standard
May 2020	General dental	Urban	VA Medical Facility Name	2	112		0	50%
May 2020	Primary care	Rural	VA Medical Facility Name	5	7		0	100%
May 2020	Specialty care	Highly rural	VA Medical Facility Name	59	40		0	100%

EXAMPLE APPOINTMENT AVAILABILITY PERFORMANCE REPORT TEMPLATE

Reporting month	Service type	Facility	Appointment type	Number of claims	Average timeliness (days)	Deviations	Percentage of claims that met VA's standard
Aug. 2021	General dental	VA Medical Facility Name	Routine	71	112	0	79%
Aug. 2021	Primary care	VA Medical Facility Name	Routine	2	7	0	100%
Aug. 2021	Specialty care	VA Medical Facility Name	Routine	775	40	0	88%

Source: GAO illustration of a Community Care Network (CCN) network adequacy performance report template. | GAO-23-105290

Notes: The figure above is intended as an example to display the types of data included in the contractor network adequacy performance reports and should not be interpreted as actual performance. The Department of Veterans Affairs (VA) uses two contractors to administer networks of providers, known as Community Care Networks, to deliver care to veterans in the community. Within the contracts for these networks, VA defined two primary standards to determine network

adequacy—maximum distances veterans may drive to community providers, and maximum wait times for appointments. These standards can vary based on certain information, such as the location of the veteran and the type of care needed. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

VA's Network Support team reviews the contractors' network adequacy performance reports to assess compliance with network adequacy requirements.[23] According to VA guidance and officials, the Network Support team, consisting of one person per CCN region, reviews the report row by row and highlights any rows in the report for which the percentage of claims that met the standard fell below 90 percent.[24] VA officials stated that this review takes about 2 hours per report per month. After review, the Network Support team reviews other supporting documentation and PPMS to try to determine the reason behind any identified failures. For example, officials stated that VA staff may use PPMS to determine whether other providers were available in the area with whom an appointment could have been scheduled. [See text box illustration of one option available to contractors unable to meet VA's standards.]

Network Access Deviation Requests in Community Care Network (CCN) Regions 1-4: an Option for Contractors When a Required Standard Cannot Be Met

If a contractor is unable to meet the network adequacy standards required by the Department of Veterans Affairs (VA) CCN contracts, they may submit a network access deviation request. According to the contracts, contractors have the option to submit deviation requests when they are unable to meet the network adequacy standards if (1) the scarcity of available providers precludes the contractor from meeting the standards, and (2) the current providers contracted with are beyond the limits of VA's time and distance standards but represent the currently available providers most accessible to that region's veterans.

Once received, VA is responsible for reviewing the deviation request and issuing an approval or denial. If the deviation request is approved, the contractors can exclude claims from performance reporting for the deviation's approved time frame (up to a year) that failed to meet the standards that fall under the approved service and location in the deviation. If denied, a contractor will continue to report any failures for those care types in those areas as part of its performance reports. According to VA data, between May 2020 and June 2022, there were 924 deviation requests submitted across CCN Regions 1-4, of which 740 have been approved by VA. Depending upon the CCN Region, the most common requests were for long-term acute care facilities, specialized dental, and allergy/immunology providers. See appendix II for further analysis.

Source: GAO analysis of VA network access deviation requests in CCN Regions 1-4. | GAO-23-105290

[23]According to VA officials, the Network Support team is housed under VA's Office of Integrated Veteran Care.

[24]According to the CCN Region 4 contract, the performance objective for CIHS is 70 percent of claims meeting the appointment availability standard.

Corrective action plans. If any performance deficiencies are identified from the network adequacy performance reports, the CCN contracts require the contractors to submit corrective action plans to VA within 10 days. The corrective action plans are to include documentation on the reason(s) for the deficiency and the timeline for correction.[25] Both contractors have submitted corrective action plans related to deficiencies identified against the drive-time standards; one contractor has submitted corrective actions plans related to its performance against the appointment availability standard.[26]

Once received, VA's Network Support team is responsible for reviewing the contractor's corrective action plan, within 7 to 10 business days, to ensure all deficiencies identified from the network adequacy performance reports are addressed in the corrective action plan. VA's team is then responsible for evaluating the contractor's findings for each documented deficiency and determining whether the identified corrective actions will address the documented deficiency. VA officials stated they hold regular calls with the contractors to assess progress on proposed corrective actions.

Not all deficiencies identified in the performance reports will result in corrective actions. For example, when reviewing a claim that failed to meet the contract's drive-time standards, if a contractor identified that there were available CCN providers within the standard for that claim, a corrective action would not be assigned. However, if there were no CCN providers within the standard for that claim, a corrective action might be issued to add more providers into the network for that care type.

Required meetings with VA and field staff. The CCN contracts include a requirement for monthly network adequacy meetings between the contractors and VA stakeholders. These meetings are intended to focus

[25]According to VA officials, these corrective action plans are actions that are self-reported by the contractors based on the data within the network adequacy performance reports, and are different than VA identified corrective actions based on performance deficiencies. As of August 2022, VA officials told us there were no active corrective action plans issued by VA.

[26]Contractor representatives stated they submitted a waiver to VA to not report corrective actions based on appointment timeliness due to COVID-19. In December 2019, a new strain of coronavirus emerged and quickly spread around the globe. In response, in January 2020, the Secretary of Health and Human Services declared a public health emergency for the United States, and in March 2020, the President of the United States declared a national emergency and the World Health Organization declared it a pandemic.

on the evaluation of network performance and any anticipated changes in network demand. The contracts also call for the contractors to be available for limited ad hoc meetings. Contractor representatives stated that they hold monthly meetings with each VA medical facility within CCN Regions 1-4 to discuss the provider networks, any future needs, and provider recruitment.[27]

VA also plans to begin monitoring contractor compliance with a contract requirement to calculate regional network adequacy performance scores, which are based on the data submitted in the network adequacy performance reports for each CCN Region.[28] These scores are used by VA to assess overall contractor regional performance and apply incentive or disincentive payments based on performance. VA officials stated they suspended the calculation and review of the scores for the CCNs in late 2019 when they began negotiating a contract modification to improve the calculation process to allow for a more accurate assessment of network adequacy. For example, according to VA officials, through the modification process, the contracts were amended to allow the contractors to remove claims from performance calculations that failed to

[27]Prior to May 2022, TriWest representatives stated that they had a mutual agreement with VA to meet monthly with each Veterans Integrated Service Network in CCN Region 4, as they felt it was important for those individuals to understand what was occurring at the VA medical facility level. In addition to those meetings, TriWest representatives stated that they held monthly meetings with a number of VA medical facilities that expressed greater concerns or needs related to network adequacy. TriWest representatives stated that as of May 1, 2022, they would no longer meet with the Veterans Integrated Service Networks monthly, and instead, meet with all VA medical facilities in Region 4 on a monthly basis. VA's health care system is divided into areas call Veterans Integrated Service Networks, each responsible for managing and overseeing the VA medical facilities within a defined geographic area.

[28]The regional scores are calculated using a formula defined in the contracts, and combine drive-time and appointment availability data from the network adequacy performance reports across all VA medical facilities for the following care types: CCN health care services (primary and specialty care), CIHS, and dental (general and specialized).

meet the standards due to veteran preference.[29] In addition, according to VA officials, VA needed to develop a mechanism to collect veteran preference data to provide to the contractors, who would in turn use this information to remove claims from performance calculations used to determine regional scores. VA executed contract modifications with the two contractors, and officials stated in August 2022 that they will begin monitoring contractor compliance with the regional score requirement in fall 2022 to fully assess network adequacy performance.

VA also conducts additional activities outside of monitoring contract requirements to assess network adequacy in CCN Regions 1-4. For example, VA is in the process of developing the means to independently assess network adequacy data, as opposed to reviewing the contractors' assessments in performance reports, according to VA officials. VA officials stated that in April 2022 they developed a reporting mechanism in an internal VA system, the Advanced Medical Cost Management Solution, to be able to validate claims data reported by the contractors.[30] VA officials stated that they plan to use the system to electronically match claims to referrals on a monthly basis so that VA can review a referral's lifecycle and independently measure network adequacy.[31] VA officials stated they began, but have not completed, this assessment in CCN Regions 1-3 in April 2022, and Region 4 data in August 2022. In addition, VA officials stated that they added a feature in PPMS in November 2021 that allows VA medical facility staff to capture whether CCN providers are accepting new patients, and to identify any additional issues that would prevent providers from accepting referrals. According to VA officials, data

[29]According to the contracts, veterans' preference, such as for a provider outside drive-time standards or for an appointment outside availability standards, is an allowed reason to exempt claims that did not meet standards from being noted as a failure on network adequacy reports. The CCN contracts also include other types of claim exceptions that the contractors can remove from their network adequacy performance reports including validated approved network deviations. Exceptions specific to drive-time include telehealth services, dialysis services, and claims for dermatology, rheumatology, non-urgent cardiothoracic surgery, and non-urgent neurosurgery. Exceptions specific to appointment availability include referrals with a clinically indicated date that is greater than 90 days and appointment no shows or cancellations recorded in VA's referral management system.

[30]VA officials stated that the Advanced Medical Cost Management Solution was initially built for financial forecasting and medical cost modeling, but as it included referral and claims data, VA developed a system enhancement to also review network adequacy. Officials stated that they started developing the system in March 2020.

[31]VA officials stated that they also will be able to monitor the number of referrals without any associated claims in a given month, quarter, or other specified time period. In addition, VA officials hope to continually improve the system to allow for more predictive analytics to proactively monitor network adequacy.

from the VA medical facilities that use this feature is extracted from PPMS weekly and shared with the contractors to allow for further analysis and determination of needs for network expansion.

VA Generally Satisfied with Contractor Performance against Network Adequacy Standards, but Assessment Was Based on Incomplete Performance Data

VA officials stated that for the period of our review—May 2020 through April 2022—they determined the contractors had generally been meeting the two network adequacy standards for drive time and appointment availability. Similarly, our analysis of aggregated data from the network adequacy performance reports submitted for CCN Regions 1-4 from May 2020 to April 2022 shows that the monthly percentage of claims that met VA's drive-time and appointment availability standards by region ranged from 86.0 to 97.0 percent and 61.8 to 92.2 percent, respectively.[32] For example, from October 2021 to March 2022, the percentage of claims meeting the drive-time standard for 90 percent of claims or more occurred the majority of the time, but the percentage for appointment availability did not reach 90 percent at any time in CCN Regions 1-4.

However, we found that the performance data the contractors submitted, and VA used to determine whether the contractors were meeting performance standards, were incomplete during the period of our review. Specifically,

- One contractor excluded 50 percent of claims that failed to meet network adequacy standards each month from the performance reports during the period of our review to estimate for veterans' preference. According to contractor representatives, this was done in agreement with VA officials to account for the lack of veteran preference data. Conversely, VA's other contractor confirmed that during the time frame of our review, it did not exclude a proxy of claims to estimate for veterans' preference.
- One of the two contractors was not submitting required appointment availability performance data from May 2020 through August 2021.[33] Contractor representatives stated that they initially requested a waiver to suspend appointment availability reporting due to the onset of COVID-19. VA officials confirmed the contractor submitted a waiver, but stated VA did not approve the waiver, and provided guidance to

[32]VA and the contractors reviewed performance against a 90 percent benchmark for most services. See appendix III for our full analysis of this data and its limitations.

[33]Although this contractor was not submitting appointment availability data to VA, contractor representatives stated that they discussed any appointment availability concerns during monthly meetings with the VA medical facilities.

the contractor, through contracting guidance, to begin submitting data in May 2020.

Despite stating that they review the contractors' network adequacy performance reports on a monthly and quarterly basis, we found that VA officials were not aware of this incomplete contractor data. First, VA officials did not have any documentation or knowledge of the contractor's stated agreement with the department to remove a percentage of claims that did not meet network adequacy standards from reporting to account for veterans' preference.[34] Second, VA officials were unable to provide a reason for their failure to notice that appointment availability data was not being submitted by one contractor almost 1.5 years after a request to the contractor to do so. VA's lack of oversight raises concerns that the department lacks a means to ensure that the contractors are submitting complete network adequacy performance data.

VA's CCN contracts outline the data that must be reported by the contractors in order to assess network adequacy performance. Moreover, VA's contracting guidance required one contractor to begin submitting appointment availability performance data in May 2020. In addition, federal internal control standards state that management should obtain reliable data from external sources based on the identified requirements and conduct ongoing monitoring to ensure effectiveness of processes and identify any issues.[35] Incomplete performance data also raises questions as to whether VA's favorable assessment of contractor performance against the standards is warranted. Without a means to ensure that the contractors are submitting complete performance data, VA is limited in its ability to monitor the extent to which the contractors are ensuring that the CCNs are adequate to meet veterans' needs. If VA's current monitoring processes are unable to ensure the contractors submit complete data that complies with contract requirements, VA may be unable to reliably assess network adequacy performance. This could ultimately affect veterans' access to community care if the networks are not meeting identified adequacy standards.

Our review of the network adequacy performance reports and contract modifications also found changes to the way performance data has been

[34]In October 2022, VA officials indicated through technical comments that they conducted further review of this issue, and found no documentation that VA had approved the contractor's actions to remove a percentage of failed claims from performance reporting.

[35]See GAO-14-704G.

reported over the course of our review, which limited our ability to assess contractor performance over time. However, VA officials stated they have modified its contracts to ensure more consistent reporting of performance data moving forward. For example, we found

- network adequacy performance reports were not similarly formatted that would allow easy comparisons over time in CCN Region 1 until May 2020, and in CCN Region 4 until November 2021,
- VA negotiated a contract modification to combine the highly rural and rural standards in Region 4 in August 2021, and Regions 1-3 in June 2022, affecting the standard certain claims would need to meet, and
- VA negotiated a contract modification in July 2021 to incorporate what was originally CCN Region 6 (containing the Pacific Islands) into the Region 4 contract, adding claims data to one Region.

VA officials said that as of August 2022, all contract modifications have been executed for CCN Regions 1-4 that would affect network adequacy performance reports.

VA Medical Facilities' Experiences and Results of Our Covert Testing Reveal Potential Challenges with Contractors Meeting VA's Routine Appointment Availability Standard

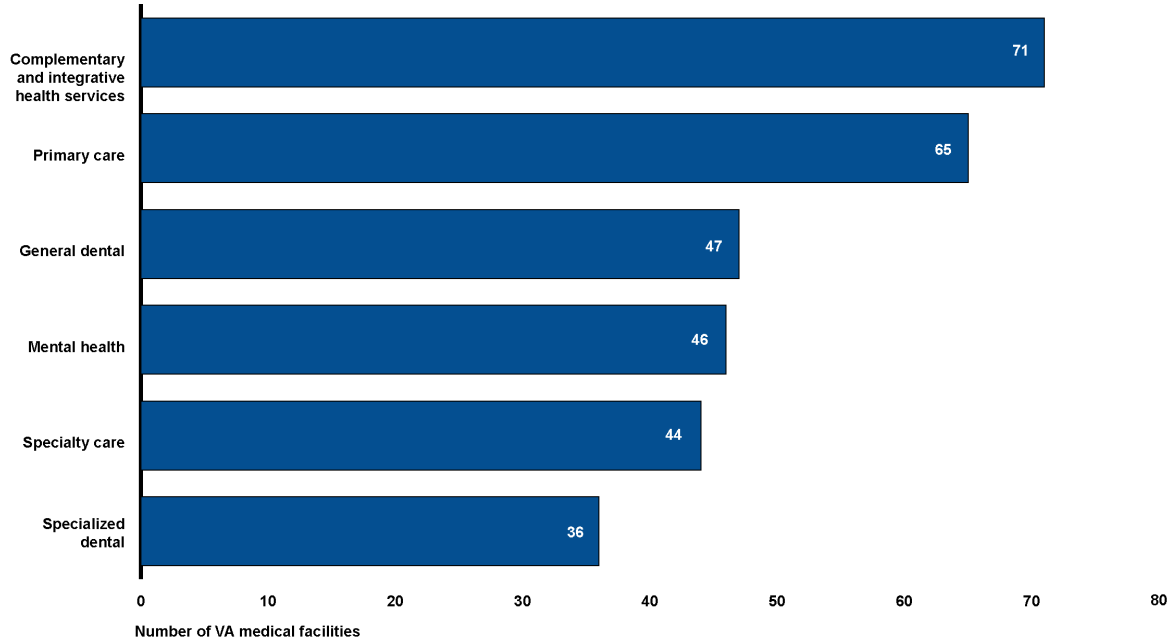
Officials from the 127 VA medical facilities who responded to our survey reported challenges scheduling routine appointments with certain types of CCN providers within the 30-day appointment availability standard. Our covert attempts to schedule appointments with 80 CCN providers revealed similar timeliness challenges. In addition, respondents reported inaccuracies in VA's Provider Profile Management System (PPMS), and we found, through our covert testing, providers listed in PPMS that were no longer participating in the CCN. These findings are in contrast to VA's assessment that the contractors have generally been meeting the network adequacy standard for appointment availability.[36]

[36]We conducted a survey of the 138 VA medical facilities in Regions 1-4 for which network adequacy data is reported, and we received responses from 127 of these facilities (92 percent). Not all VA medical facilities responded to every question. We fielded the survey between February and April 2022. The survey targeted VA's primary community care contact for each facility, often the head of the facility's community care office. For more information on the survey and responses, see appendix IV.

Survey of VA Medical Facilities and Covert Calls Reveal Challenges Scheduling Timely Routine Appointments for Some Care Types

Officials from more than half (55.9 percent) of the 127 VA medical facilities responding to our survey reported being able to schedule a majority of complementary and integrative health services (CIHS) and primary care appointments within the 30-day standard for the previous month. However, the percentage of VA medical facilities that reported being able to schedule the majority of appointments for some care types—specialty care, dental care, and mental health—within 30 days ranged from 28 percent to 37 percent.[37] (See fig. 3.)

Figure 3: Number of VA Medical Facilities Reporting More Than Half of Appointments Scheduled within 30 Days by Care Type, April 2022



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. The survey asked

We conducted 80 covert tests (i.e. undercover calls) to a non-generalizable sample of general dentists and gastroenterologists listed in PPMS as participating in CCN Regions 1-4 in March 2022. During the calls, we posed as a veteran researching CCN providers who needed either a routine dental cleaning or services for gastroesophageal reflux disease. We asked the sample of providers whether (1) they participated in the CCN, (2) were accepting new patients, and (3) the date of the next available appointment for those services.

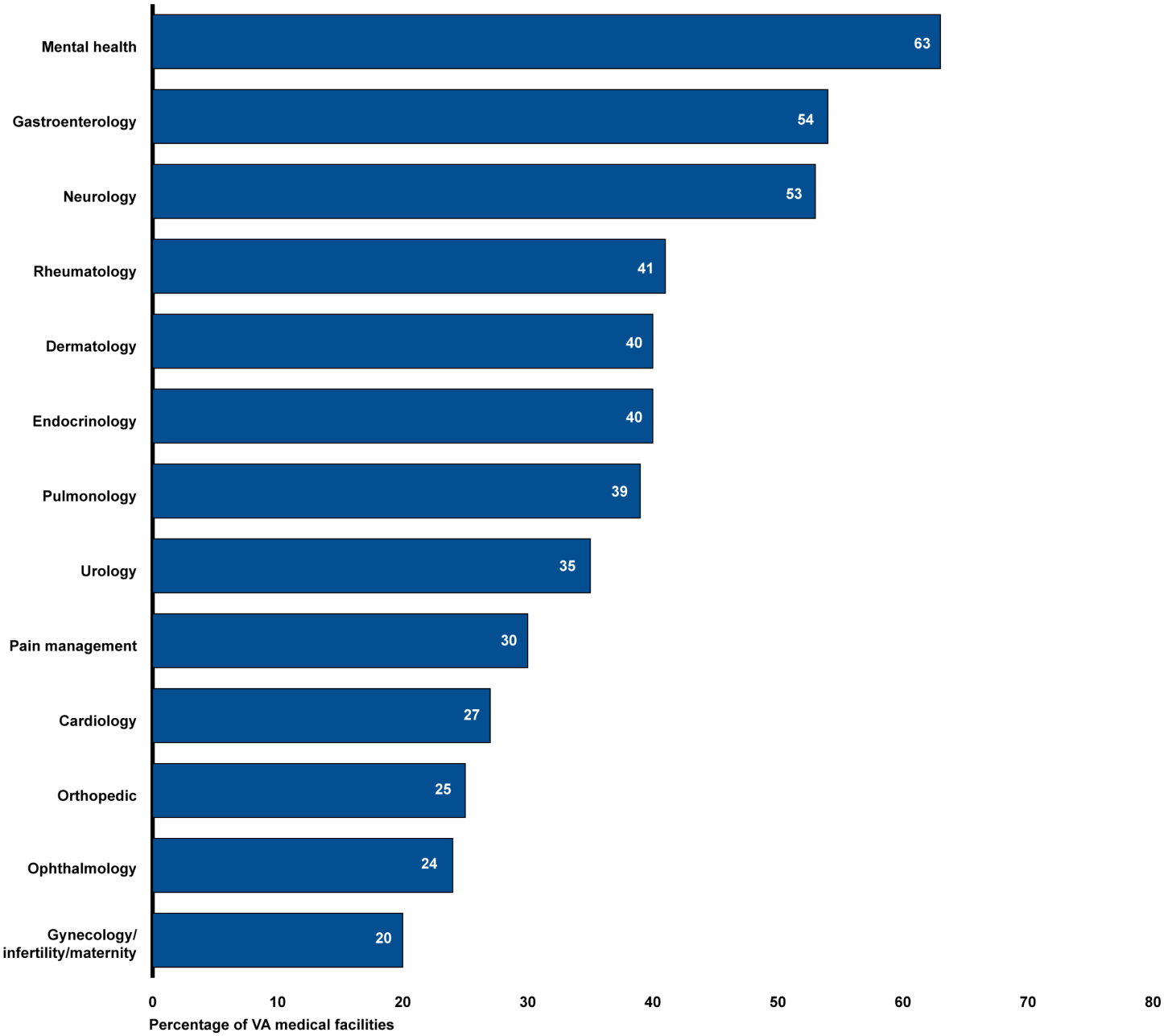
[37]Our survey asked for the VA medical facility's experience with appointment timeliness in the previous month. Of the 127 facilities that responded, 74 percent of facilities indicated that the previous month was reflective of the previous 3 months.

respondents to report the number of calendar days from the clinically indicated date, which is the date an appointment is deemed clinically appropriate by the referring VA provider, they scheduled more than half of initial appointments by care type. Of the 127 VA medical facility survey respondents in Community Care Network Regions 1-4, 126 completed this question.

When asked about specific types of health care services for which schedulers experienced the most difficulty obtaining an initial appointment within 30 days, VA medical facility officials identified several services. Officials from more than 50 percent of responding VA medical facilities indicated that mental health, gastroenterology, and neurology were among the service types with the least appointment availability. Additionally, officials from around 40 percent of responding VA medical facilities cited rheumatology, dermatology, and endocrinology among service types with the least appointment availability.[38] See fig. 4 for the health care services for which at least 20 percent of VA medical facilities reported limited availability. Appendix IV contains a full list of all service types that VA medical facilities indicated were among their least available service types.

[38]According to VA officials, rheumatology and dermatology are areas known to have large gaps of providers, which are therefore exempt from network adequacy performance calculations by the two contractors.

Figure 4: VA Medical Facilities' Reporting of Health Care Service Types with the Least Appointment Availability, April 2022



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Notes: Of the 127 VA medical facility respondents in Community Care Network Regions 1-4, 125 respondents completed this question. Respondents could select more than one option.

In addition, during our 80 covert calls to general dentists and gastroenterologists listed as participating in CCN Regions 1-4 we found similar results to our VA medical facility survey responses. Of the 40 general dental providers we spoke with, 32 confirmed they participated in the CCN, with 22 (69 percent) of those providers having an available appointment for a routine cleaning within 30 days. Of the 40 gastroenterology providers we spoke with, 37 confirmed they participated in the CCN, with 18 (49 percent) of those providers having an available appointment for the treatment of gastroesophageal reflux disease within 30 days.

Reported Challenges Affecting Timely Appointment Scheduling

We also surveyed VA medical facility officials familiar with the CCNs regarding any challenges they face that may impact timely appointment scheduling. Respondents cited a number of challenges, including (1) an insufficient number of CCN providers, (2) providers' limited appointment availability, (3) an insufficient number of VA medical facility scheduling staff, and (4) inaccurate provider data in PPMS. We have previously reported on, and have made recommendations to address, some of these issues, though the recommendations remain unimplemented.

Insufficient number of CCN providers. More than half of responding VA medical facility officials familiar with the CCNs reported that an insufficient number of providers in the CCNs significantly impacted their ability to schedule mental health and specialized dental appointments within 30 days.[39] Further, officials from nearly a third of VA medical facilities reported an insufficient number of providers in the CCNs impacted timely scheduling of specialty care appointments. See the text box below for examples from survey respondents of their experiences with insufficient numbers of CCN providers.

Community Care Officials' Perspectives on Supply of Community Care Network (CCN) Providers

"The number one problem is [the] continuing decrease in supply of healthcare providers in our region which is having an impact in both the community as well as the VA."

"There are very few mental health providers in our CCN, [and] when there is, they have very limited availability."

"Mental health access is very limited in this area."

"We don't have adequate coverage in our area and not many dental providers willing to work with us."

Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

[39]VA officials noted that mental health and dental services were the top categories of care impacted by COVID-19 across the health care industry due to challenges such as location closures and increased demand.

We previously reported in September 2020 and June 2021 on VA medical facility staff concerns with regard to the number of providers in the CCN. In 2020, we found that staff from five VA medical facilities we conducted site visits to in CCN Region 1 felt the provider network was not adequate, and in 2021, staff from six VA medical facilities we spoke with expressed concerns with the CCN, including gaps in the network for certain types of specialty care.[40]

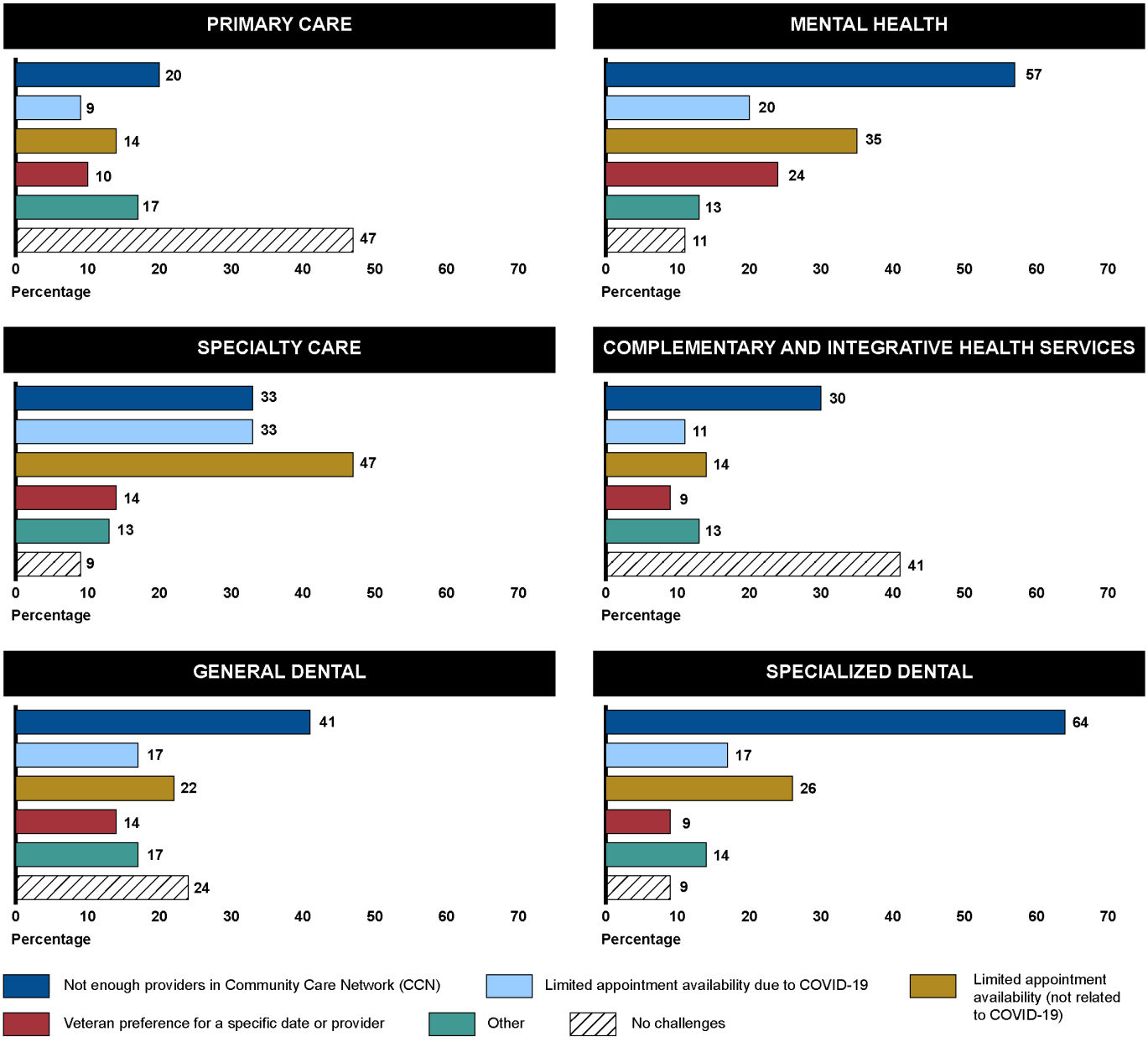
To help address these concerns, Optum and TriWest representatives told us they have processes for reviewing and assessing network adequacy needs. For example, Optum representatives said they review the number of providers in the network based on certain factors and meet monthly with VA medical facilities to discuss current networks, future needs, and provider recruitment. TriWest representatives told us they use a number of tools to assess appointment referral patterns by specialty and location to determine the optimal number of providers in the CCN and meet monthly with VA medical facilities to discuss specific needs or concerns.

Limited provider appointment availability. Forty-seven percent of VA medical facility officials reported that providers' limited appointment availability—not related to COVID-19—significantly impacted scheduling for specialty care appointments, and 35 percent of officials indicated limited appointment availability impacted the scheduling of mental health appointments.

The survey also asked VA medical facility officials about additional challenges affecting appointment availability, including limited appointment availability due to COVID-19 and veterans' preference for a specific date or provider. Officials from VA medical facilities in our survey did not report that these challenges significantly impacted their ability to schedule timely appointments. See figure 5 for VA medical facilities' responses regarding certain factors that significantly affected appointment availability by type of care.

[40]See GAO-20-643 and GAO-21-476. Our 2020 report examined the appointment scheduling process established under the VCCP, and focused on CCN Region 1 as its deployment schedule best aligned with our reporting time frames. Our 2021 report examined the impact of COVID-19 on veterans' access to community care, and we conducted interviews with one VA medical facility in CCN Region 1, two facilities in Region 2, one facility in Region 3, and two facilities in Region 4.

Figure 5: Factors Significantly Impacting Initial Appointment Availability with Community Care Network (CCN) Providers within 30 Days by Care Type

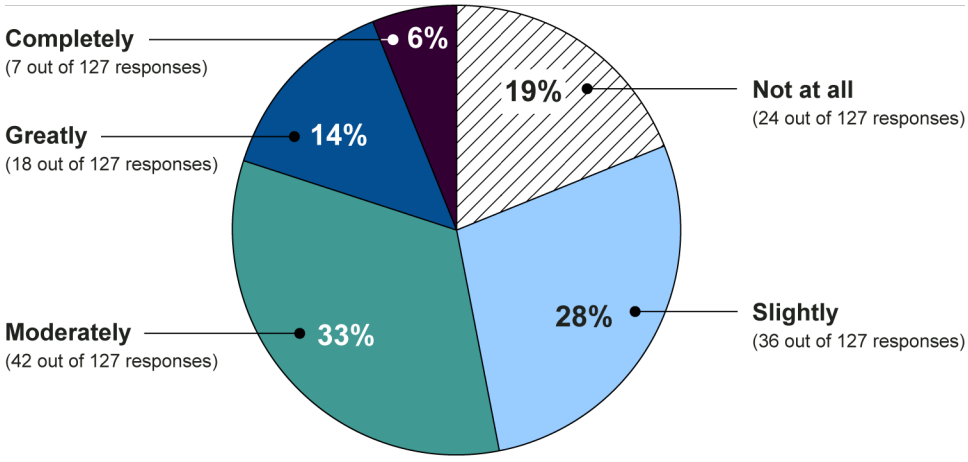


Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April 2022. | GAO-23-105290

Notes: Other challenges survey respondents reported included lengthy administrative processes required by CCN providers and payment issues cited by CCN providers. Percentages may not add to 100 due to rounding.

Insufficient number of VA medical facility community care scheduling staff. In our survey, VA medical facility officials familiar with the CCNs reported that internal staffing was a challenge affecting the scheduling of timely appointments.[41] (See fig. 6.) Our survey found that only 6 percent of VA medical facility officials reported sufficient scheduling staff for managing community care appointments. In contrast, 19 percent reported not at all having sufficient staffing to manage these appointments. (See the text box below for examples from survey respondents of their experiences with insufficient numbers of staff to schedule appointments.)

Figure 6: Percentage of VA Medical Facility Survey Respondents Reporting Sufficient Scheduling Staff to Manage Community Care Appointment Scheduling



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Note: All 127 VA medical facility survey respondents located in Community Care Network Regions 1-4 responded to this question.

[41]VA medical facility staff typically schedule community care appointments on behalf of veterans. After receiving a referral from a VA provider and determining a veteran's eligibility for community care, the appointment scheduling process includes multiple steps when facility staff schedule on behalf of the veteran: (1) gathering any veteran scheduling preferences, (2) identifying and contacting community providers to determine appointment availability, (3) sending the VCCP authorization and veteran's information and medical documentation to the provider, (4) scheduling the appointment, and (5) communicating appointment details to the veteran.

Community Care Officials' Perspectives on Staffing Levels to Manage Community Care Appointments

"[Our] community care team has experienced critically low staffing ratios…and turn-over despite aggressive recruiting efforts. The largest factor delaying the scheduling of care within 30 days is our ability to process the requests timely."

"Shortage of scheduling staff has been our biggest challenge. We had less than 50 percent staffing of schedulers by November 2021. At present we are at 77 percent. Our team has worked long hours, sometimes 7 days a week to try and keep up with [scheduling]."

Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Understaffed community care offices may affect a facility's ability to handle veterans' community care referrals in a timely manner. We previously reported on Veterans Community Care Program referral workload and facility community care staffing concerns in September 2020 and June 2021. Specifically, in September 2020 we noted that while VA developed a staffing tool to help facilities determine the number of staff they needed to manage community care, most facilities in CCN Region 1 in February 2020 did not have the number of staff recommended by the tool and were not meeting timeliness metrics for appointment scheduling.[42] We recommended that VA direct VA medical facility leadership to assess their community care staffing and resource needs, and develop a plan to address any identified risks to their ability to schedule appointments in a timely manner. VA agreed with the recommendation, but as of August 2022, has not fully implemented it. We reported again in June 2021 that staff from six selected VA medical facilities believed their community care offices were understaffed, with added challenges resulting from COVID-19, and reiterated our previous recommendation.[43]

PPMS information is often inaccurate and incomplete. Our survey results also show that VA officials have concerns about the accuracy of PPMS, which identifies participating community providers. VA medical facility officials reported in our survey that providers may not be aware

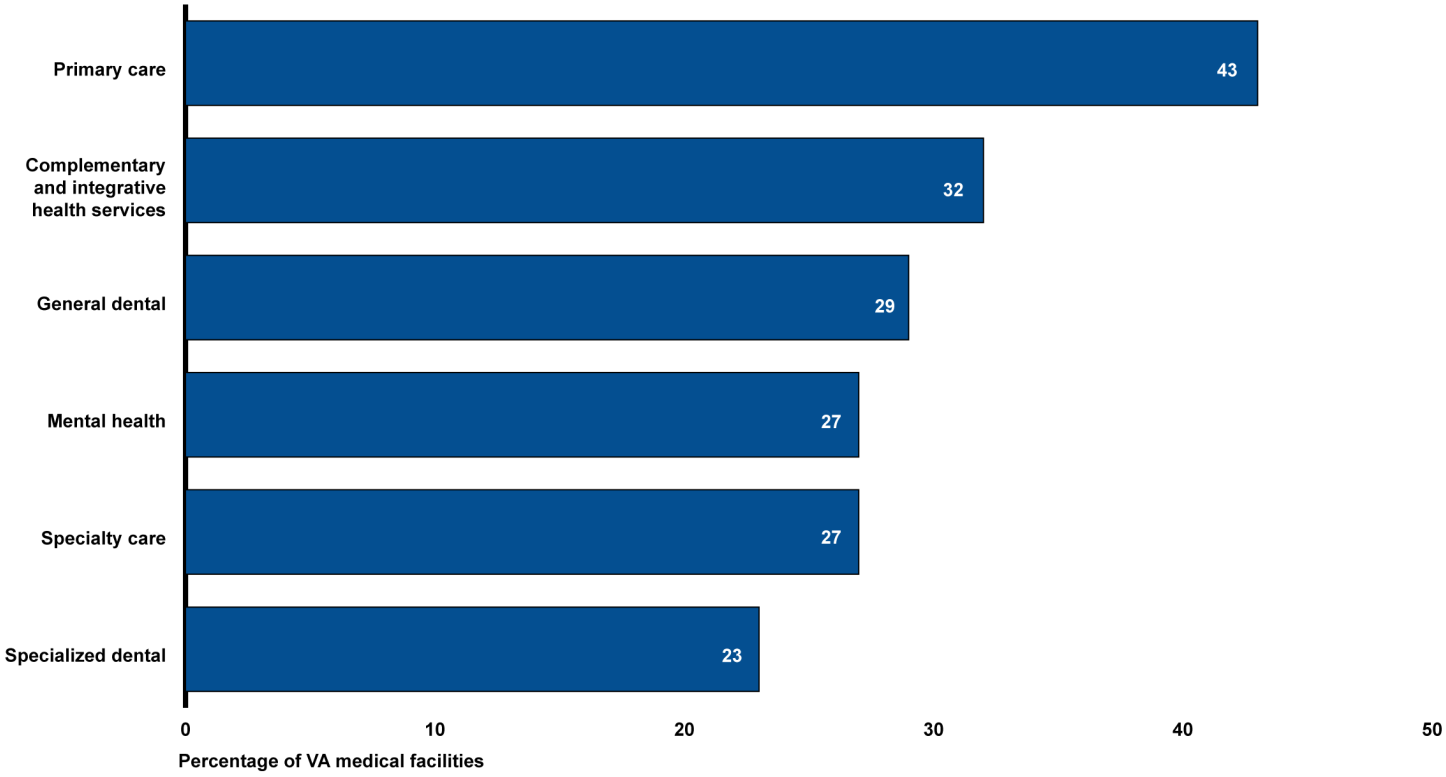
[42]See GAO-20-643. There are 40 VA medical facilities in CCN Region 1. We did not review staffing in the other CCN regions in this report.

[43]See GAO-21-476.

they are enrolled in the CCN, and our covert call results supported this.[44] Across all service types, fewer than half of VA medical facility officials indicated that PPMS greatly or completely reflected the providers in the CCN who were available to see veterans. (See fig. 7.) For example, 39 percent of VA medical facility officials reported that PPMS often or always listed providers who no longer accept CCN referrals for primary care. Similarly, our covert calls found that eight of the 40 general dental providers we contacted and three of the 40 gastroenterologists we contacted either no longer participated in the CCN, or were unsure if they participated in the program.

[44]In addition to PPMS, some VA medical facility staff discussed the limited use of the HealthShare Referral Manager, VA's referral management system, by community providers to coordinate with the VA facility. For example, one VA medical facility official responded that a large number of the CCN providers in their network do not use the HealthShare Referral Manager, and therefore, referrals must be faxed or emailed to the providers, of which some say they never receive the information. We previously reported in September 2020 that although VA officials intended for the HealthShare Referral Manager to be the primary tool used by VA facility staff to interact with community providers, only a small portion of CCN providers were using the system. We recommended VA conduct a review of community provider enrollment and use of the HealthShare Referral Manager to identify any barriers to use. VA has taken some action, but as of August 2022, has not fully implemented this recommendation. See GAO-20-643.

Figure 7: Percentage of VA Medical Facilities Reporting the Provider Profile Management System Greatly or Completely Reflected Community Care Network Providers Available to See Veterans by Care Type, April 2022



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

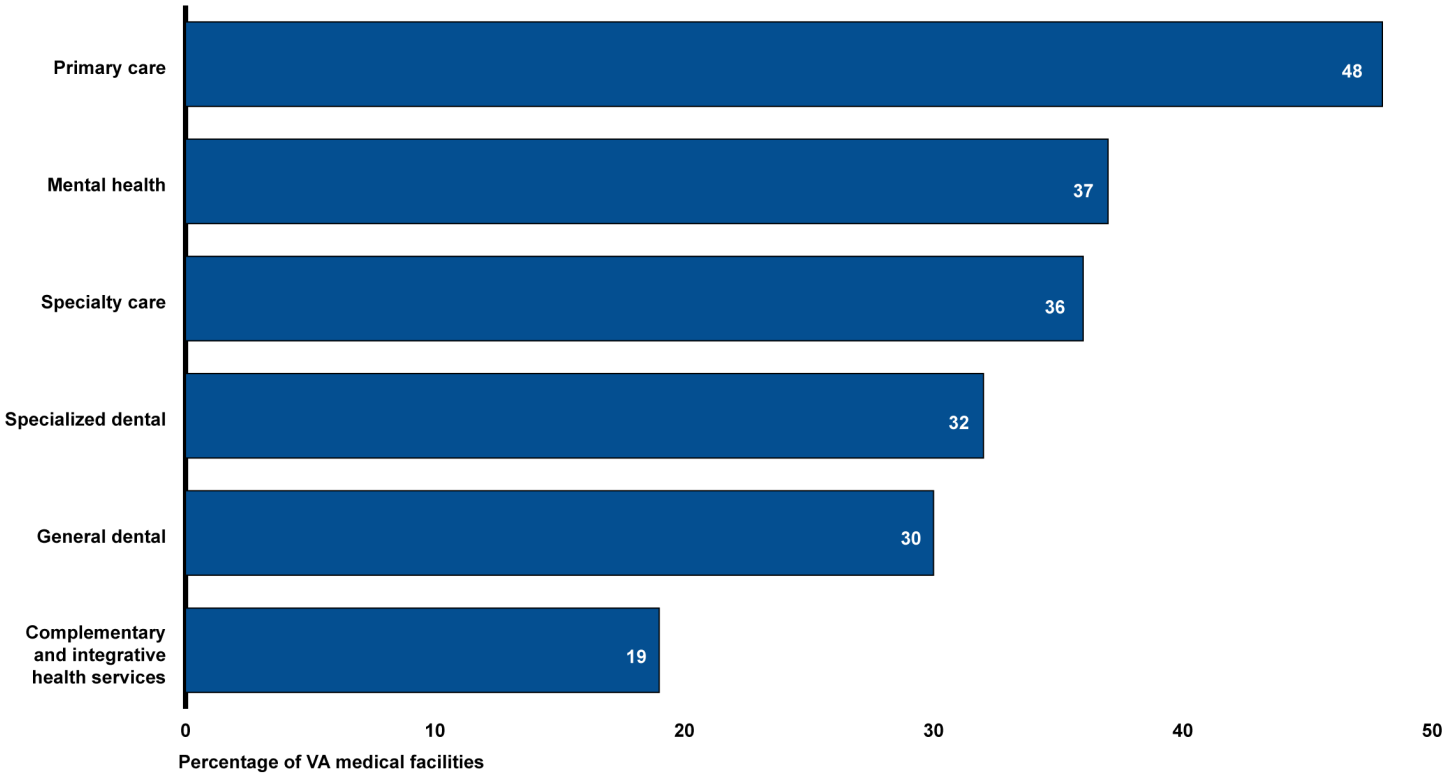
Notes: The Provider Profile Management System is VA's master database of community providers that receives and stores information such as provider demographic information and the types of services the provider is authorized to deliver. CIHS is complementary and integrative health services, which includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. All 127 VA medical facility survey respondents located in Community Care Network Regions 1-4 responded to this question.

We asked VA medical facility officials who responded that PPMS did not greatly or completely reflect CCN providers available to see veterans how often the information in PPMS was incomplete or inaccurate. (See text box below for examples from survey respondents of their experiences with inaccurate and incomplete PPMS information.)

- Officials from nearly half (48 percent) of VA medical facilities reported that provider information was often or always incomplete or inaccurate for primary care providers;

- More than a third of officials from VA medical facilities reported incomplete or inaccurate provider information for mental health and specialty care providers;
- More than a quarter of officials from VA medical facilities stated that PPMS was often or always incomplete or inaccurate for general and specialized dental care providers. (See fig. 8.)

Figure 8: Percentage of VA Medical Facilities Reporting Challenges with PPMS Citing Information Is Often or Always Inaccurate or Incomplete by Care Type, April 2022



Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Notes: PPMS is VA's master database of community providers that receives and stores information such as provider demographic information and the types of services the provider is authorized to deliver. CIHS is complementary and integrative health services, which includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. The number of VA medical facility officials responses varied by care type; respondents who reported that PPMS was not at all, slightly, or moderately reflective of the providers in the CCN who are able to see veterans were asked to report how often they contacted providers, by care type, and encountered inaccurate or incomplete information in PPMS. We did not ask respondents who reported that PPMS was greatly or completely reflective of providers in the CCN who are able to see veterans to identify further challenges.

Community Care Officials' Perspectives on the Accuracy and Completeness of VA's Provider Profile Management System (PPMS) Information

"Specialty in PPMS is incorrect or the provider may be listed for a specialty but they do not really provide the service."

"The issue with PPMS and specialized dental, is that general dentists who do a small amount of limited specialty care are listed as being a specialty dentist. The vast majority of the time, they cannot meet the needs of the Veteran who needs actual specialty dental care."

"The use of PPMS is extremely frustrating. . . We run into everything from an incorrect address, incorrect phone number, incorrect fax number, the provider listed is no longer part of the office, the office never credentialed with CCN but that one specific provider did so we can only refer to one provider in an office with 10 available providers, the facility isn't aware they are part of CCN, the facility has decided they will no longer accept referrals, the facility has never accepted referrals and will not start, the facility only accepts internal facility physician referrals, and even the specialty of care listed in PPMS is inaccurate."

"Correct providers are generally in PPMS but the demographic information is not always correct....i.e. address, telephone and fax."

Source: GAO survey of community care officials at 127 Department of Veterans Affairs (VA) medical facilities, administered February-April, 2022. | GAO-23-105290

Our sample of covert calls to gastroenterologists and dental providers in Regions 1-4 also found 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 CCNs. (See fig. 9.) These inaccuracies are inconsistent with federal internal control standards, which call for management to use quality information to achieve the entity's objectives, specifically here, the provision of timely appointments to veterans.[45] Inaccurate or incomplete PPMS information can cause scheduling delays and duplication of work, such as taking additional time to add notes on incorrect provider information for other scheduling staff and notifying the contractor of inaccurate information, for VA medical facility staff.

[45]See GAO-14-704G.

Figure 9: Examples of Inaccurate or Incomplete Information in the Provider Profile Management System, March 2022

Phone number

- When contacting a gastroenterology practice in CCN Region 1, the listed PPMS number led us to a billing company, who was able to provide a correct number for the practice.
- When contacting a gastroenterology practice in CCN Region 3, the listed PPMS number led us to a person who stated the area code was off by one number, and they receive these calls constantly.

Physical address

- When contacting a general dental provider in CCN Region 1, staff stated that the address listed in PPMS did not have any dentists on staff, but offered other practices within their network that had dentists and accepted VA referrals.
- When contacting a gastroenterology practice in CCN Region 1, staff stated that there was no longer a practice listed at the PPMS address, but offered information on another practice within their network that accepted VA referrals.
- When contacting a gastroenterology practice in CCN Region 4, staff stated that the PPMS address was no longer valid as they had built a new practice in the last year.

Care provided

- When contacting a general dental provider in CCN Region 2, staff stated that their practice only performs oral surgeries, and did not offer general dental services like routine cleanings.
- When contacting a general dental provider in CCN Region 3, staff stated that they did not offer general dental services like routine cleanings, and only accepted VA referral for specialized dental related to periodontics.
- When contacting a gastroenterology practice in CCN Region 2, staff stated that they were a small, critical care facility, and no longer had a gastroenterologist on staff.

Legend: CCN=Community Care Network; PPMS=Provider Profile Management System, VA=Department of Veterans Affairs.

Source: GAO analysis of information obtained during covert calls to 80 CCN general dentists and gastroenterologists, March 2020. | GAO-23-105290

Notes: We conducted 80 covert tests (i.e. undercover calls) to a non-generalizable sample of general dentists and gastroenterologists listed as participating in CCN Regions 1-4 in March 2022. During the calls, we posed as a veteran researching CCN providers who needed either a routine dental cleaning or services for gastroesophageal reflux disease. We asked the sample of providers whether (1) they participated in the CCN, (2) were accepting new patients, and (3) the date of the next available appointment for those services.

TriWest representatives told us that the information in PPMS may be inaccurate or incomplete because provider information can change after it has been entered into PPMS; for example, if a provider moves or changes practices. Contractor representatives also stated that the information they submit to VA to populate PPMS should be correct when it is obtained from the provider and uploaded to PPMS. The representatives explained that they validate the information during the credentialing process, but that they rely on providers to update them when this information changes. According to contractor representatives, this may cause inaccuracies when providers do not share updated information in a timely manner.[46]

VA officials stated that they cannot correct the information in PPMS themselves and rely on Optum and TriWest for all PPMS data corrections.[47] As a result, VA officials stated that they added a notes feature to PPMS for facility staff to use to add internal notes regarding corrections, such as noting an updated phone number or whether a provider is not currently accepting veterans, which other schedulers can see. In addition, contractor representatives told us that VA facility staff can submit update requests to the contractors through email or telephone.

The contractors do not have a process for proactively identifying inaccurate provider information; rather, the contractors generally rely on schedulers at VA medical facilities to identify errors with provider information in PPMS.[48] When VA schedulers identify incomplete or inaccurate information in the course of scheduling veteran appointments, contractor representatives explained that contractor staff must first validate the information with the provider before they can update the information in PPMS. Optum representatives stated they try to address

[46]Credentialing is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. VA's contracts require Optum and TriWest to credential providers before they participate in the CCNs, and at least every three years thereafter.

[47]Although VA developed PPMS, VA officials explained that they do not own the provider data within the system. According to one contractor, information is automatically uploaded into PPMS's automated data feed that sends new information to PPMS on a daily basis.

[48]TriWest representatives stated that TriWest conducts a quarterly directory audit of provider data in which data elements are verified and scored for accuracy. In addition, many of TriWest's network subcontractors utilize provider data management platforms that allow for provider attestation of data on a frequent basis.

changes to provider information daily and also try to resolve any provider demographic updates they receive from VA within 30 days, a metric the contractor has established for itself. TriWest representatives also stated they attempt to make any updates to provider information within 30 days. According to Optum representatives, the validating process can take up to 30 days, and in some cases, if a provider does not respond, the contractor is not able to validate the information with the provider and therefore cannot update PPMS.

We have also previously reported on problems with the accuracy of PPMS provider data.

- In September 2020, we reported that schedulers at VA medical facilities had difficulties scheduling community care appointments because of issues with the quality of provider address data in PPMS.[49]
- Additionally, in December 2021, we reported on weaknesses in the oversight of community provider address data in PPMS.[50] Specifically, we reported that VA did not have a means for verifying that the address listed in PPMS was actually the address where providers provide care to veterans. In that December 2021 report, we made ten recommendations to VA, including several to improve provider address controls to address risks related to VA's inability to ensure correct address information in PPMS.[51] VA concurred with these recommendations but has not yet implemented them as of August 2022.

Under the VA MISSION Act, VA is assigned responsibility to oversee the Veterans Community Care Program, including ensuring that veterans' appointments are scheduled in a timely manner.[52] Inaccurate or outdated information may show a potentially inaccurate inflation of the number of CCN providers in the networks, if providers listed in PPMS are not actually accepting patients, including veterans. Inaccurate and incomplete

[49]See GAO-20-643.

[50]See GAO-22-103850.

[51]The recommendations in this report are specific to provider addresses, and would not impact other provider inaccuracies in PPMS, like availability to see veterans.

[52]VA MISSION Act of 2018, Pub. L. No. 115-182, tit. I, § 101, 132 Stat. 1393, 1395 (2018), codified at 38 U.S.C. § 1703(a)(2)(A).

PPMS data may also inhibit VA's ability to provide timely care for veterans.

Conclusions

As required by the CCN contracts, VA regularly collects performance data on two primary standards from the contractors in CCN Regions 1-4 to determine the adequacy of the community provider networks in those regions. While this performance data showed that the contractors generally met the standards during the time we reviewed, these assessments were not based on all claims, and therefore, give a potentially misleading picture of network adequacy. Moving forward, VA states it has plans to begin independently validating contractor performance data. Taking this action, in addition to ensuring the contractors submit complete performance data, should help VA identify the extent to which its networks are adequate to meet veterans' needs.

Further, the results of our survey found challenges scheduling timely appointments, some of which could be addressed by VA implementing our earlier recommendations. In addition, we found VA schedulers encountered inaccurate information in PPMS when scheduling appointments, which is burdensome, as schedulers must independently determine correct phone numbers and addresses or identify another provider who is participating in the CCN to successfully schedule an appointment, potentially delaying veteran care.

Recommendations for Executive Action

We are making the following two recommendations to VA:

The Undersecretary for Health should ensure that Community Care Network contractors report complete claims data when calculating performance against VA's network adequacy standards. In cases where VA has made agreements with the contractors to exclude certain claims, those reasons should be clearly documented by VA. (Recommendation 1)

The Undersecretary for Health should review its processes for monitoring the accuracy and completeness of contractor-submitted provider data in PPMS and implement strategies under current or future contracts to increase the accuracy of provider information stored in PPMS. For example, VA could require the contractors to use proactive processes to ensure data accuracy. (Recommendation 2)

Agency Comments

We provided a draft of this report to VA for review and comment. In its comments, reproduced in appendix V, VA concurred with our recommendations, and identified actions it is taking to implement them.

VA also provided technical comments, which we incorporated as appropriate.

We are sending copies to the appropriate congressional committees, the Secretary of Veterans Affairs, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

Sharon M. Silas
Director, Health Care

List of Requesters

The Honorable Bernard Sanders
Chairman
Committee on the Budget
United States Senate

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate

The Honorable Mark Takano
Chairman
Committee on Veterans' Affairs
House of Representatives

The Honorable Julia Brownley
Chairwoman
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

Appendix I: Objectives, Scope, and Methodology

The objectives of our report were to: (1) describe how the Department of Veterans Affairs (VA) monitors contractor compliance with network adequacy requirements for Community Care Network (CCN) Regions 1-4; (2) examine the extent to which VA's contractors are meeting network adequacy standards in CCN Regions 1-4; and (3) examine the experiences of VA medical facility officials when scheduling routine appointments for veterans in CCN Regions 1-4.

Network adequacy performance report data analysis. To examine the extent to which VA's contractors are meeting network adequacy standards in CCN Regions 1-4, we reviewed VA's CCN contracts and required reporting documents, including network adequacy performance reports, corrective action plans, and contractor requests for deviations from the network adequacy standards. We analyzed network adequacy performance data for drive time and appointment availability submitted by the CCN contractors in Regions 1-4 (see table 2 for the time frames we reviewed).[1]

Table 2: Time Frames of GAO's Review of Contractor-Submitted Network Adequacy Performance Reports, Community Care Networks (CCN) Regions 1-4

	GAO review time frames	
CCN region	**Drive-time reports**	**Appointment timeliness reports**
Region 1	May 2020 to Apr. 2022	Aug. 2021 to Apr. 2022
Region 2	May 2020 to Apr. 2022	
Region 3	Aug. 2020 to Apr. 2022	
Region 4	Oct. 2020 to Mar. 2022	Oct. 2020 to Mar. 2022

Source: GAO analysis based on time frames chosen for review of contractor-submitted network adequacy performance reports. | GAO-23-105290

For drive-time performance data, we reviewed contractor-reported data on adjudicated claims for primary care, specialty care, complementary and integrative health services (CIHS), general dental care, and specialized dental care for urban, rural, and highly rural veteran

[1]We chose these time frames to ensure the contractors' performance reports reflected network adequacy data that occurred (1) after the CCNs had been fully implemented in each Region, and (2) after the performance report templates were standardized.

locations.[2] For appointment availability performance data, we reviewed contractor-reported data on adjudicated claims for the same service types we reviewed for drive-time performance that were scheduled as routine care.[3] We reviewed the data to identify any obvious errors, and interviewed VA officials and contractor representatives about the data. On this basis, we determined these data were sufficiently reliable for the purpose of our objective.

The VA contractor reports organize adjudicated claims and percentages of claims that met the standards for the prior month by VA facility, service type, and in the case of drive time, rurality of veteran location, and in the case of appointment availability, urgency of the appointment. We aggregated the percent of claims that met VA performance standards for drive time and appointment availability by month for reporting purposes. We first multiplied the total number of claims by the overall percentage that met VA's performance standard to obtain the number of claims that met standards by each observation in the contractor-submitted network adequacy performance reports. We then summed the total number of claims and the number of claims that met VA's performance standards by reporting period (aggregating across facilities, service types, and rurality). Finally, we divided the number of summed claims that met VA's performance standard by the summed total number of claims to obtain the percent of claims that met VA's performance standards by month. See appendix III for the results of this data analysis.

Survey of VA medical facility officials. To examine the experiences of VA medical facility officials when scheduling routine appointments for veterans in CCN Regions 1-4, we conducted a survey of VA medical facility officials who oversee the Veterans Community Care Program across all 138 VA medical facilities that the contractors report network adequacy performance data for in Regions 1-4. We received responses

[2]VA used the term "general care" in the original contracts for CCN Regions 1-3 to cover specialty care services, and officials stated as a lesson learned, changed the term to "specialty care" in the Region 4 contract. VA officials stated that they modified the contracts to update this category to specialty care across all regions. Therefore, we will refer to this type of care as specialty care for this report. The contractors also report performance data for pharmacy and assisted reproductive technology services, which is outside the scope of our report.

[3]Routine care is care that is not deemed emergent or urgent by the VA ordering provider. The contractors also report appointment availability performance data for appointments categorized as emergent or urgent, which is outside the scope of our report.

from 127 of these VA medical facilities, and analyzed those responses.[4] The survey, administered between February 28, 2022, and April 22, 2022, covered topics including the length of time to schedule initial appointments with CCN providers, CCN provider availability, and challenges facilities face when scheduling CCN appointments and when using VA's database of community providers, the Provider Profile Management System (PPMS). The survey also included open-ended questions, such as challenges with appointment availability. While the survey represents 92 percent of the VA medical facilities for which community care network adequacy data is reported in Regions 1-4, results may not be generalizable to those who did not respond to the survey or to VA facilities in other CCN Regions. Further, survey results only represent the point in time the survey was completed. See appendix IV for the results of this survey analysis.

Covert testing. To examine the experiences of VA medical facility officials when scheduling routine appointments for veterans in CCN Regions 1-4, we performed a number of covert tests (i.e., undercover calls) in March 2022, posing as a veteran researching CCN providers. Specifically, we performed 80 covert tests to a non-generalizable sample of general dentists and gastroenterologists listed in PPMS as participating in CCN Regions 1-4—10 dental providers and 10 gastroenterologists per region—stating we needed either a routine dental cleaning or services for gastroesophageal reflux disease.[5] We inquired whether the selected provider (1) was participating in the CCN, (2) was accepting new patients, and (3) the date of the next available appointment for the selected services. The results of our covert testing are illustrative only of the behaviors we experienced during the calls with selected providers, and are not generalizable to all dental or gastroenterology providers or all CCN Regions.

[4]Of the 138 VA medical facilities we contacted, 135 were VA health care systems or VA medical centers, one was a Multi-Specialty Community-Based Outpatient Center, one was an outpatient clinic, and one was a federal healthcare facility that combines VA and Department of Defense medical care in one facility.

[5]To select our sample of CCN providers, we requested a list from VA of all general dentists or gastroenterologists listed as participating in the CCN in Regions 1-4, in addition to provider data such as address and phone number. VA provided the requested data from its Provider Profile Management System, VA's master database of community providers. Once we received the data, we performed data checks and filtered for duplicate provider addresses to randomly select our sample. We called general dental and gastroenterology providers and practices. For the purposes of this report we refer to both as "providers."

We conducted this performance audit from June 2021 to November 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigative standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Appendix II: GAO Analysis of Network Adequacy Performance Deviation Requests, Community Care Network Regions 1-4

The Department of Veterans Affairs' (VA) Community Care Network (CCN) contracts require the contractors to maintain provider networks that are adequate in size, scope, and capacity to ensure that veterans receive timely access to care. VA defined two primary standards within the contracts to measure network adequacy—maximum drive times to CCN providers and maximum appointment availability wait times—the maximum amount of time veterans should have to wait to obtain an appointment. These standards vary by factors such as care type and veteran geographic location.

If the contractors are unable to meet the network adequacy standards required by the contract, they may submit network access deviation requests. According to the contracts, contractors have the option to submit deviation requests to VA when they are unable to meet the network adequacy standards if (1) the scarcity of available providers precludes the contractor from meeting the standards, and (2) the current providers contracted with are beyond the limits of VA's time and distance standards but represent the currently available providers most accessible to that region's veterans. VA staff review the requests and issue a determination of approval or denial. Approved deviations are only valid for approved time frames, and contractors must resubmit requests when the time frame expires.

According to VA data, between May 2020 and June 2022, there have been 924 deviation requests submitted across CCN Regions 1-4.[1] (See table 3.) Depending upon the CCN Region, the most common requests were for long-term acute care facilities, specialized dental, and allergy/immunology providers.

[1]We did not include deviation requests for pharmacy services because they are outside the scope of our review. There were also three deviation requests approved for telehealth delivery of mental/behavioral health services in Regions 1-3. VA officials explained that these were not true deviations, and intended as more of a waiver to allow for mental health services to be delivered in a veteran's home during COVID-19, with the deviation approval process the best mechanism to approve the request.

Table 3: Number of Network Access Deviation Requests in Community Care Network (CCN) Regions 1-4, May 2020 through June 2022

CCN region	Total number of deviation requests	Number of approved requests[a]	Number of denied requests	Number of uncategorized requests[b]
Region A	**181**	125	54	2
Region B	**446**	371	67	8
Region C	**238**	191	43	4
Region D	**59**	53	6	0
Total	**924**	**740**	**170**	**14**

Source: GAO analysis of Department of Veterans Affairs (VA) network access deviation requests. | GAO-23-105290

Notes: VA uses two contractors to administer regional networks of providers, known as Community Care Networks, to deliver care to veterans in the community. Within the contracts for these networks, VA defined two primary standards to determine network adequacy. If the contractors are unable to meet the network adequacy standards, they may submit a network access deviation request, of which VA reviews and approves, approves with changes, or denies. Regional data has been masked to protect potentially sensitive information.

[a]The number of approved deviation requests includes those requests categorized as approved with changes.

[b]Deviation requests that were not categorized as approved, approved with changes, or denied.

Appendix III: GAO Analysis of Contractor-Submitted Network Adequacy Performance Reports, CCN Regions 1-4

The Department of Veterans Affairs (VA) established five regional networks of community providers, known as Community Care Networks (CCN), to deliver health care services to veterans when they have issues accessing care at VA medical facilities. Two contractors are responsible for maintaining the CCN provider networks, known as CCN Regions 1-5, and ensuring they are adequate in size, scope, and capacity to ensure veterans receive timely access to care. Under the CCN contracts, the contractors are required to meet two primary standards VA established to ensure network adequacy in regions 1-4. These standards specify maximum distances veterans may drive to community providers, and maximum wait times for appointments.[1]

- VA's drive-time standard depends on the veteran's location and care referral type. Drive times are calculated from the veteran's home address on record with VA to the provider's address.[2]
- VA's appointment availability standard depends on the urgency of the needed care (regardless of care type). The maximum appointment availability time for routine care (that is, care not considered emergent) is 30 days, calculated from the date VA sends the referral to the contractor to the date the veteran receives care, using claims and referral data.[3] (See table 4.)

Table 4: Selected Network Adequacy Standards as of August 2022, CCN Regions 1-4

	Maximum drive times			Maximum appointment availability wait times
Location of veteran	**Primary care**	**General dental**	**Specialty care/ Specialized dental/CIHS**	**Routine care**
Urban	30 minutes	30 minutes	45 minutes	30 days
Rural and highly rural	45 minutes	45 minutes	100 minutes	30 days

Source: GAO analysis of the Community Care Network (CCN) contracts for Regions 1-4. | GAO-23-105290

Notes: The Department of Veterans Affairs (VA) uses two contractors to administer networks of providers, known as CCNs, to deliver care to veterans in the community. The first contracts for the CCNs awarded in fiscal year 2019 included different drive-time standards for highly rural veterans—60 minutes for primary care, 90 minutes for general dental, and 180 minutes for specialty care,

[1]We did not include Region 5, Alaska, in our review as the drive-time and appointment availability standards are different from those found in Regions 1-4.

[2]The calculation of drive times does not factor in traffic.

[3]This standard does not include the time it takes VA to process the referral before sending to the contractors. VA also defined appointment availability standards for emergent and urgent care—24 hours and 48 hours, respectively. Emergent and urgent care are outside the scope of our review.

specialized dental, and complementary and integrative health services (CIHS). According to VA officials, VA changed the standards in order to increase access to care. General dental includes services such as exams and cleanings; specialized dental includes services such as endodontics; and CIHS include services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care needed by the veteran that is not considered emergent or urgent, encompassing all care types.

The CCN contracts require the contractors to submit network adequacy performance reports to VA on a regular basis that show each contractor's performance against VA's network adequacy standards.[4] To develop these reports, the contractors calculate the percentage of adjudicated (paid) claims from the previous month that met VA's drive-time and appointment availability standards, and submit these data in spreadsheets to VA. The performance reports for drive-time standards are based on claims data for each service type measured independently by rurality per VA medical facility.[5] The performance reports for appointment availability are based on claims data for each service type measured independently by urgency per referral originating from a VA medical facility.[6] The performance reports include data on the following services:

- primary care;
- specialty care, which includes mental health;
- complementary and integrative health services (CIHS), such as biofeedback, massage therapy, Native American healing, and relaxation techniques; and
- dental services, which comprise both general dental (e.g., exams, cleanings) and specialized dental (e.g., endodontics, periodontics).[7]

[4]The contracts for Regions 1-3 require the network adequacy performance reports to be submitted to VA monthly, while the Region 4 contract requires submission on a quarterly basis.

[5]According to VA officials, the contractors measure network adequacy performance for the claim for the first appointment associated with a veteran's referral against both standards. Officials explained that a referral can be associated with multiple appointments, resulting in multiple claims.

[6]VA officials confirmed that while the claims may be adjudicated in a specific month, the date the care took place may not coincide with the month in which the claim was adjudicated. VA allows community providers up to 180 days to file claims for rendered services to the CCN contractors for payment.

[7]The CCN contracts provide for other services, like urgent care and pharmacy, but are outside the scope of this review.

Our review of the network adequacy performance reports found the data was incomplete during the period of our review, and there were changes to the way performance data was reported, limiting our ability to assess contractor performance over time. However, VA has modified its contracts to ensure more consistent reporting of performance data moving forward. For example, we found

- One contractor excluded 50 percent of claims that failed to meet network adequacy standards each month from the performance reports to estimate for veterans' preference—that is, when a veteran prefers a provider located further than drive-time standards, or an appointment scheduled beyond appointment availability standards. Conversely, VA's other contractor did not exclude a proxy of claims to estimate veterans' preference.
- One contractor was not submitting required appointment availability performance data from May 2020 to August 2021[8].
- Network adequacy performance reports were not similarly formatted that would allow easy comparisons over time in CCN Region 1 until May 2020, and in CCN Region 4 until November 2021.
- VA negotiated a contract modification to combine the highly rural and rural standards in Region 4 in August 2021, and Regions 1-3 in June 2022, affecting the standard certain claims would need to meet.
- VA negotiated a contract modification in July 2021 to incorporate what was originally CCN Region 6 (containing the Pacific Islands) into the Region 4 contract, adding claims data to one Region.

Acknowledging data limitations, we reviewed the contractor's network adequacy performance reports submitted for CCN Regions 1-4 for both drive time and appointment availability, and aggregated the percentage of claims each month that met the standards. Given the variability in network adequacy reporting between and within contractors, we were unable to use contractor network performance reporting to assess performance against VA's contract requirements, or to compare performance across CCN Regions. As such, the descriptions of findings from contractor reports below are meant to summarize contractor network adequacy

[8]Although this contractor was not submitting appointment availability data to VA, contractor representatives stated that they discussed any appointment availability concerns during monthly meetings with the VA medical facilities.

reporting by region and different time frames for informational purposes only.

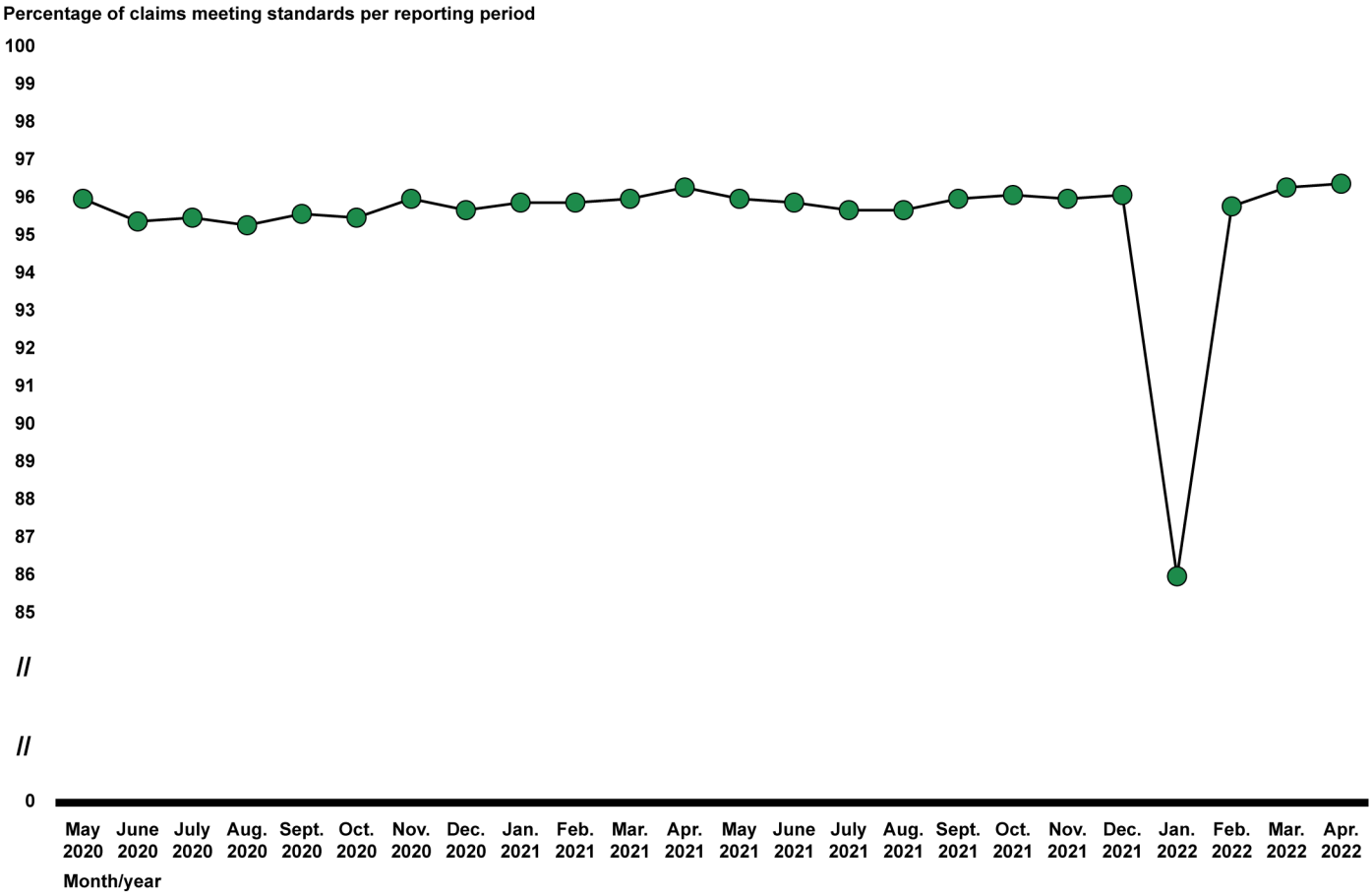
CCN Region 1. The implementation of CCN Region 1 was completed in December 2019. Due to variations in how the network adequacy performance reports were structured in CCN Region 1 from February 2020 to April 2020, we chose to separately report Region 1's drive-time performance report data into two time frames—pre standardized reporting (March 2020 to April 2020) and post standardized reporting (May 2020 to April 2022).[9]

Performance report data show that the monthly percentage of claims that met VA's drive-time standard ranged from 96.1 percent in March 2020 to 96.4 percent in April 2020 in CCN Region 1 prior to when the network adequacy performance reports were reformatted to separate dental care into two categories – general dental and specialized dental.

After data reformatting, performance report data showed that the monthly percentage of claims that met VA's drive-time standard from May 2020 to April 2022 ranged from 86.0 to 96.4 percent in CCN Region 1. (See fig. 10.)

[9]Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 performance report data is a reflection of the claims adjudicated in September 2021.

Figure 10: Community Care Network (CCN) Region 1 Aggregated Network Adequacy Performance Report Data Compared against VA's Drive-Time Standard, May 2020 to April 2022



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 performance report data is a reflection of the claims adjudicated in September 2021. Due to variations in how network adequacy performance reports were structured in CCN Region 1 from February 2020 to April 2020, we chose to review Region 1's performance report data starting in May 2020 when reporting became standardized.

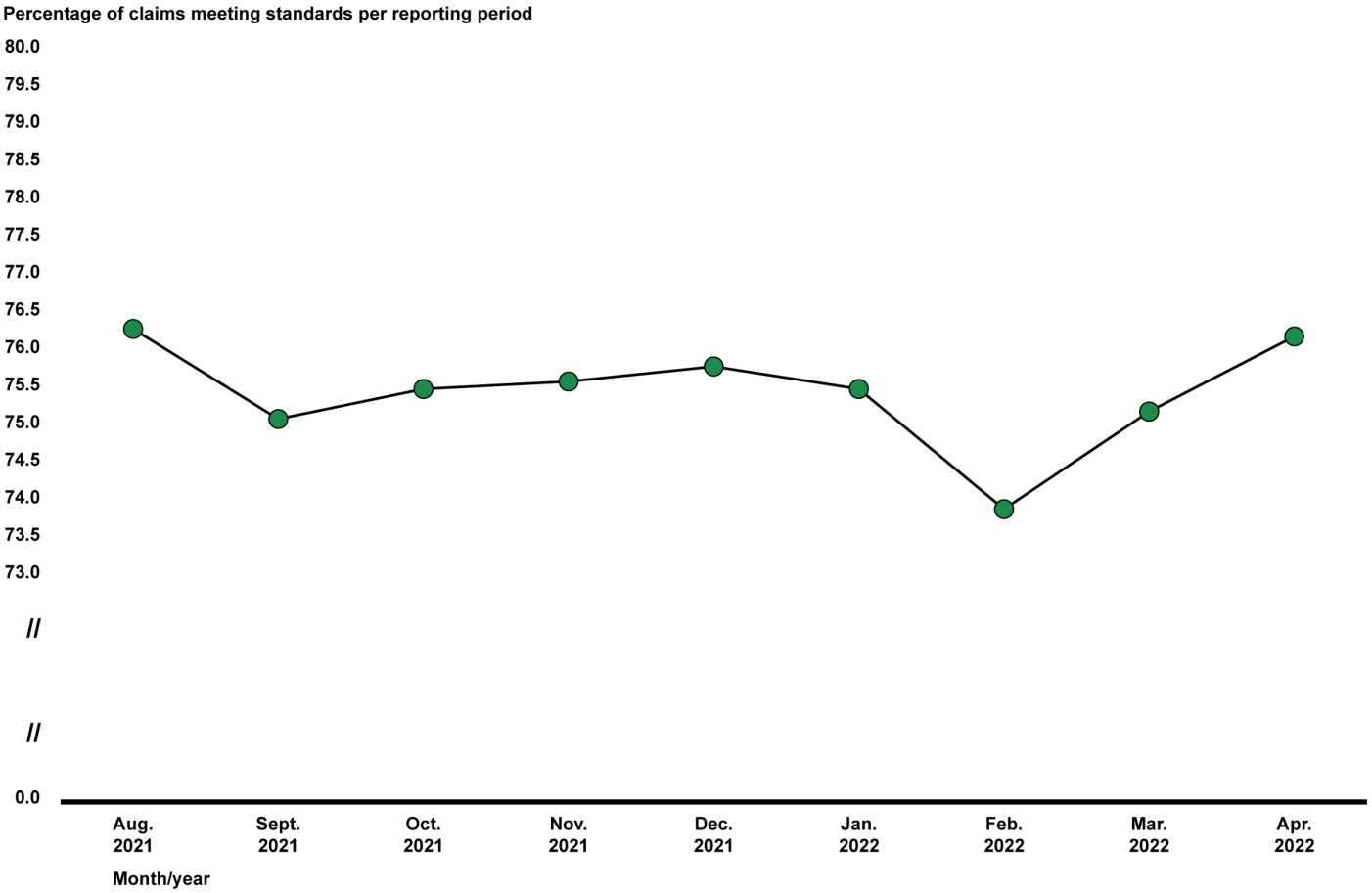
VA's CCN contractor did not begin submitting appointment availability data in their network adequacy performance reports for CCN Region 1 until August 2021. We reviewed claims for routine care appointments, which is defined as care that is not deemed emergent or urgent by the VA

ordering provider.[10] Performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard from August 2021 to April 2022 ranged from 73.9 to 76.3 percent in CCN Region 1.[11] (See fig. 11.)

[10]The contractors also report appointment availability performance data for these care types that were categorized as emergent and urgent, which is outside the scope of our report.

[11]The aggregated range we report for each Region for routine appointment timeliness does not include data for CIHS because it has a different performance standard than health care services and dental care.

Figure 11: Community Care Network (CCN) Region 1 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard, August 2021 to April 2022



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor for Region 1 did not begin submitting appointment availability data in their network adequacy performance reports for CCN Region 1 until August 2021. Routine care is care that is not deemed emergent or urgent by the VA ordering provider. Care types included in aggregation are primary care, specialty care, general dental, and specialized dental.

Further analysis of appointment availability performance data found variations in meeting VA's standard among the care types. For example, our analysis of appointment availability performance data found that the majority of claims adjudicated from August 2021 to April 2022 were for routine specialty care. Of the 619,105 claims, performance report data showed that the monthly percentage of claims that met VA's appointment availability standard ranged from 75.3 to 77.6 percent. (See table 5.)

Table 5: Community Care Network (CCN) Region 1 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard by Care Type, August 2021 to April 2022

CCN region	Types of care	Total number of claims	Range of percentages of claims that met VA's standard each month
Region 1	Primary care	3,560	37.0 to 47.2
	Specialty care	619,105	75.3 to 77.6
	General dental	4,472	58.4 to 66.1
	Specialized dental	34,205	53.8 to 60.8
	Complementary and integrative health services	4,665	68.6 to 78.7

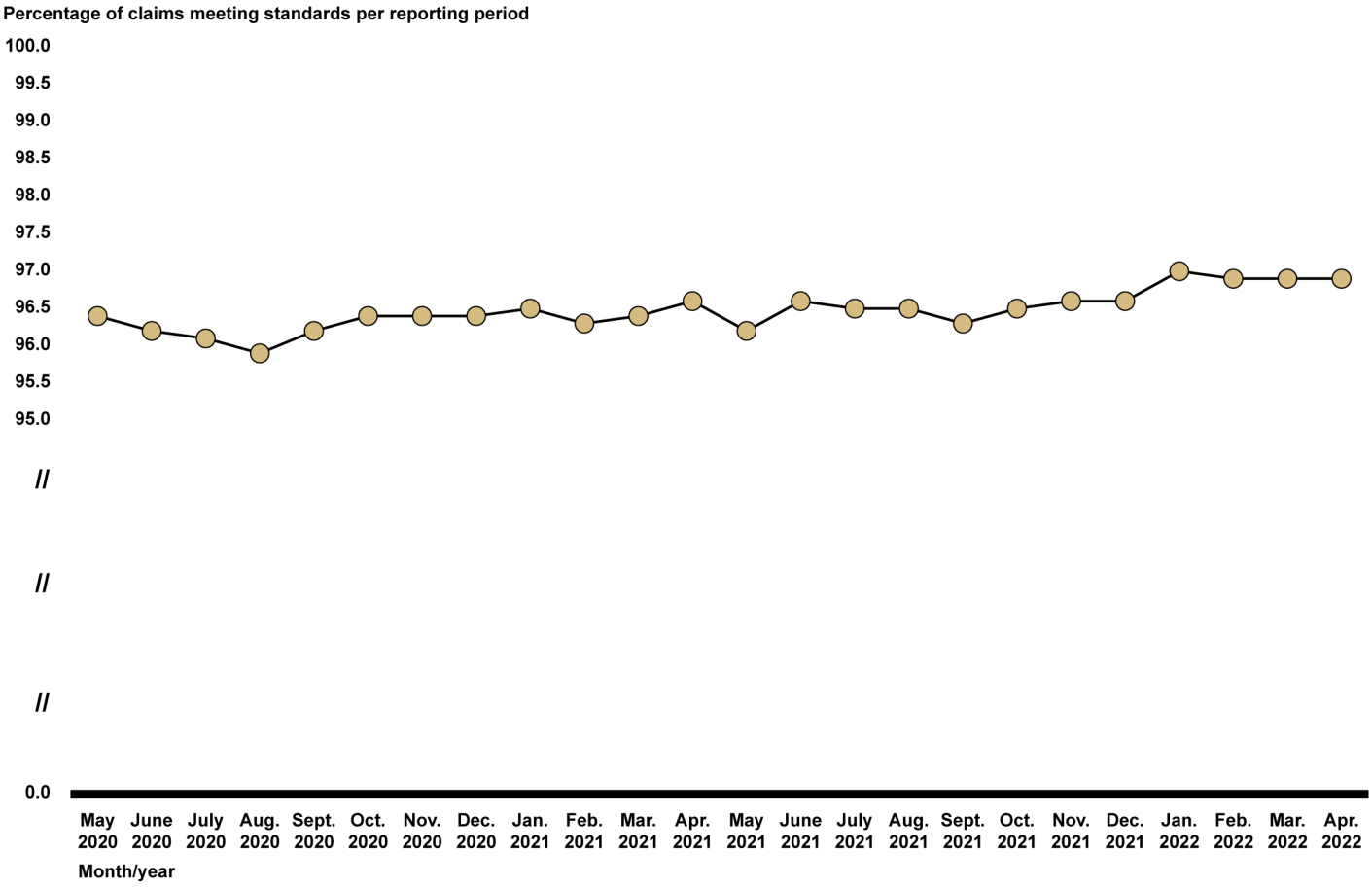
Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor did not begin submitting appointment availability data in their network adequacy performance reports for CCN Region 1 until August 2021. Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

CCN Region 2. The implementation of CCN Region 2 was completed in March 2020. We reviewed network adequacy performance report data starting in May 2020, reflecting April 2020 claims, to ensure the data no longer reflected the CCN's implementation phase.

Performance report data show that the monthly percentage of claims that met VA's drive-time standard from May 2020 to April 2022 ranged from 95.9 to 97.0 percent in CCN Region 2. (See fig. 12.)

Figure 12: Community Care Network (CCN) Region 2 Aggregated Network Adequacy Performance Report Data Compared against VA's Drive-time Standard, May 2020 to April 2022

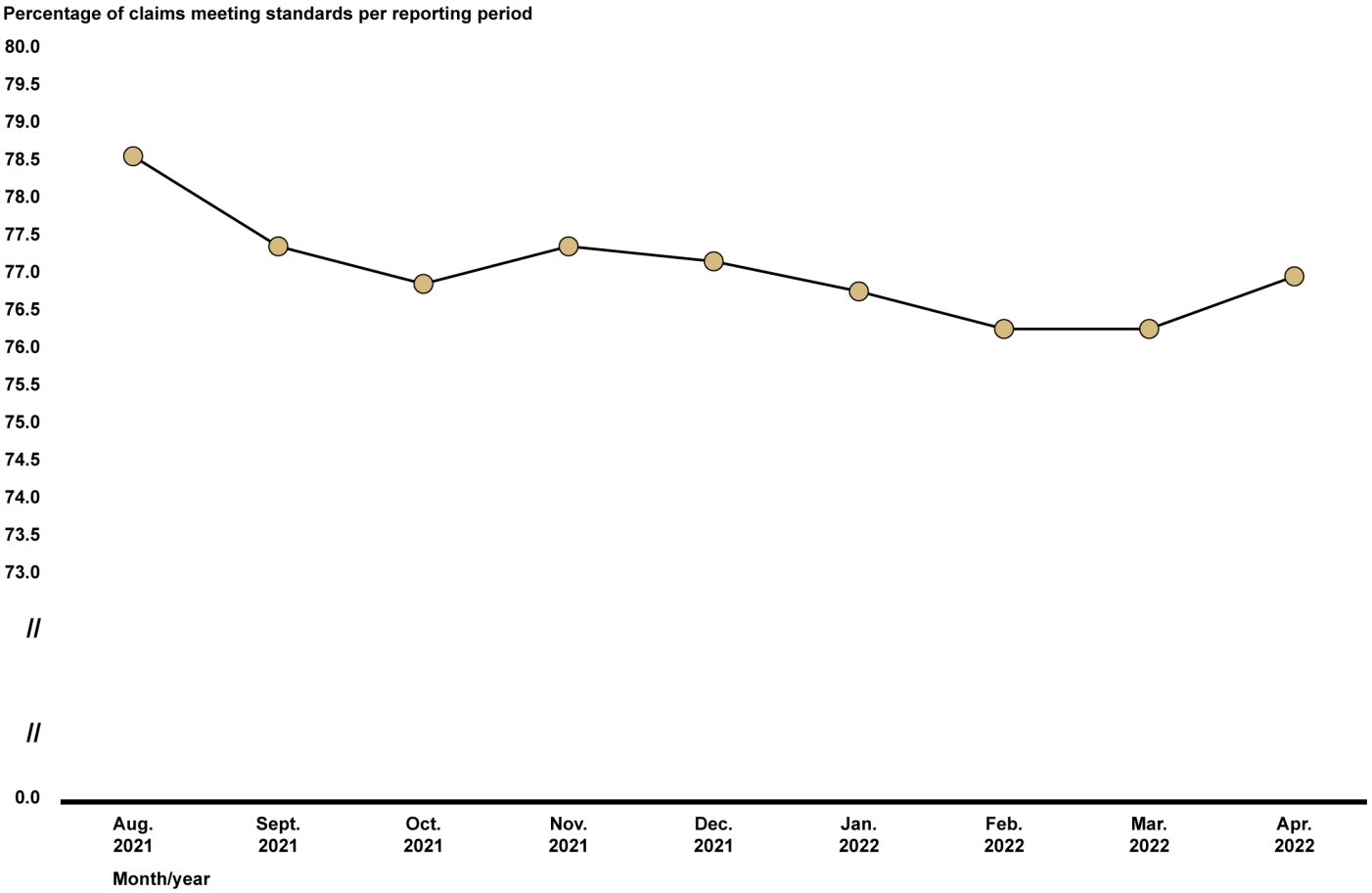


Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 performance report data is a reflection of the claims adjudicated in September 2021. The implementation of CCN Region 2 was completed in March 2020. We reviewed network adequacy performance report data starting in May 2020, reflecting April 2020 claims, to ensure the data no longer reflected the implementation phase.

VA's CCN contractor did not begin submitting appointment availability data in their network adequacy performance reports for CCN Region 2 until August 2021. Performance report data show that the monthly percentage of claims that met VA's routine appointment availability standard from August 2021 to April 2022 ranged from 76.3 to 78.6 percent in CCN Region 2. (See fig. 13.)

Figure 13: Community Care Network (CCN) Region 2 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard, August 2021 to April 2022



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor for Region 2 did not begin submitting appointment availability data in their network adequacy performance reports until August 2021. Routine care is care that is not deemed emergent or urgent by the VA ordering provider. Care types included in aggregation are primary care, specialty care, general dental, and specialized dental.

Further analysis of appointment availability performance data found variations in meeting VA's standard among the care types. For example, our analysis of appointment availability performance data found that the majority of claims adjudicated from August 2021 to April 2022 were for routine specialty care. Of the 802,525 claims, performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard ranged from 77.0 to 79.3 percent. (See table 6.)

Table 6: Community Care Network (CCN) Region 2 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard by Care Type, August 2021 to April 2022

CCN region	Types of care	Total number of claims	Range of percentages of claims that met VA's standard each month
Region 2	Primary care	7,286	55.3 to 61.1
	Specialty care	802,525	77.0 to 79.3
	General dental	3,008	55.9 to 72.1
	Specialized dental	23,841	59.2 to 66.4
	Complementary and integrative health services	3,928	66.0 to 78.1

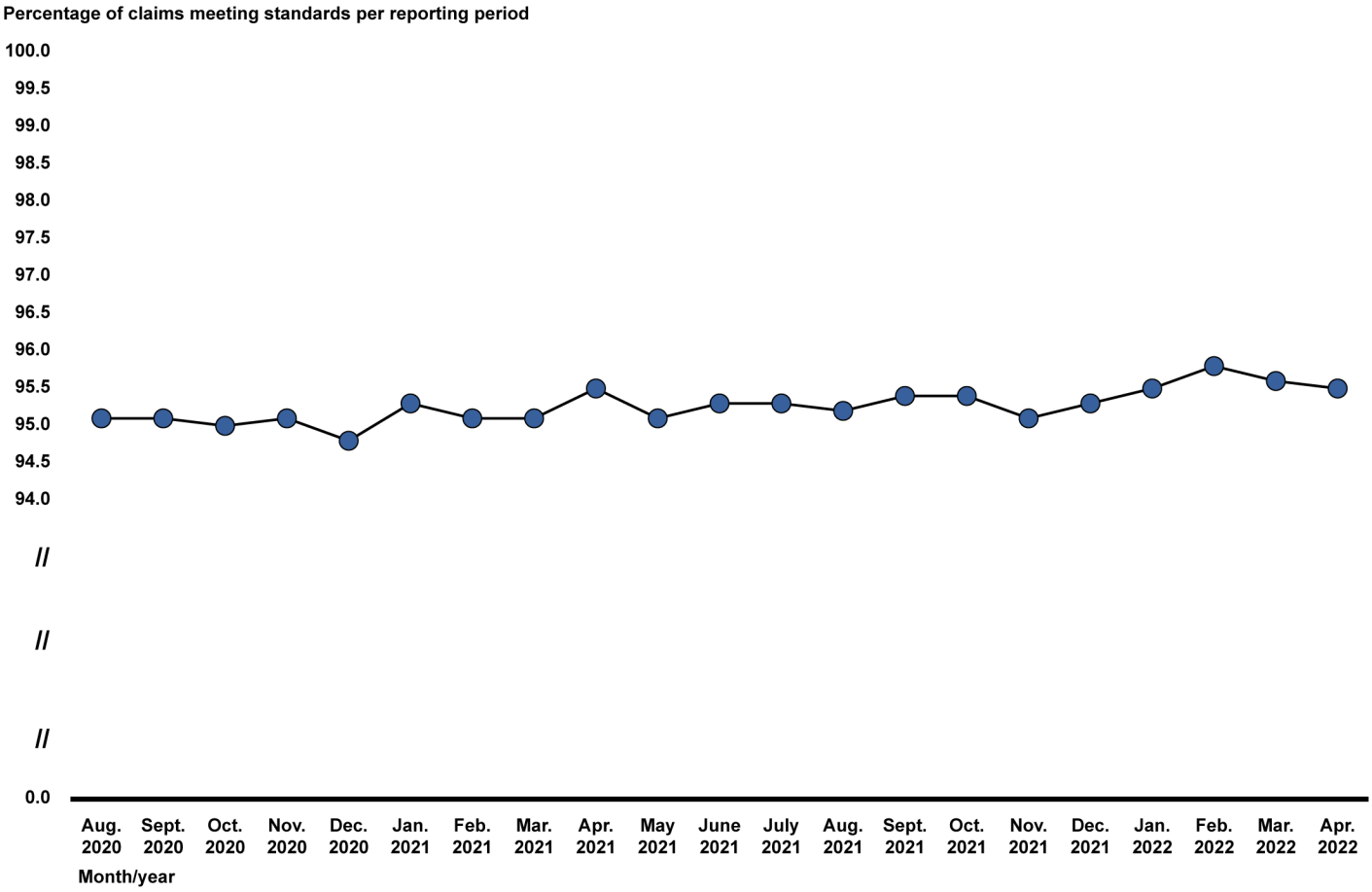
Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor for Region 2 did not begin submitting appointment availability data in their network adequacy performance reports until August 2021. Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

CCN Region 3. The implementation of CCN Region 3 was completed in June 2020. We reviewed network adequacy performance report data starting in August 2020, reflecting July 2020 claims, to ensure the data no longer reflected the CCN's implementation phase.

Performance report data showed that the monthly percentage of claims that met VA's drive-time standard from August 2020 to April 2022 ranged from 94.8 to 95.8 percent in CCN Region 3. (See fig. 14.)

Figure 14: Community Care Network (CCN) Region 3 Aggregated Network Adequacy Performance Report Data Compared against VA's Drive-Time Standard, August 2020 to April 2022

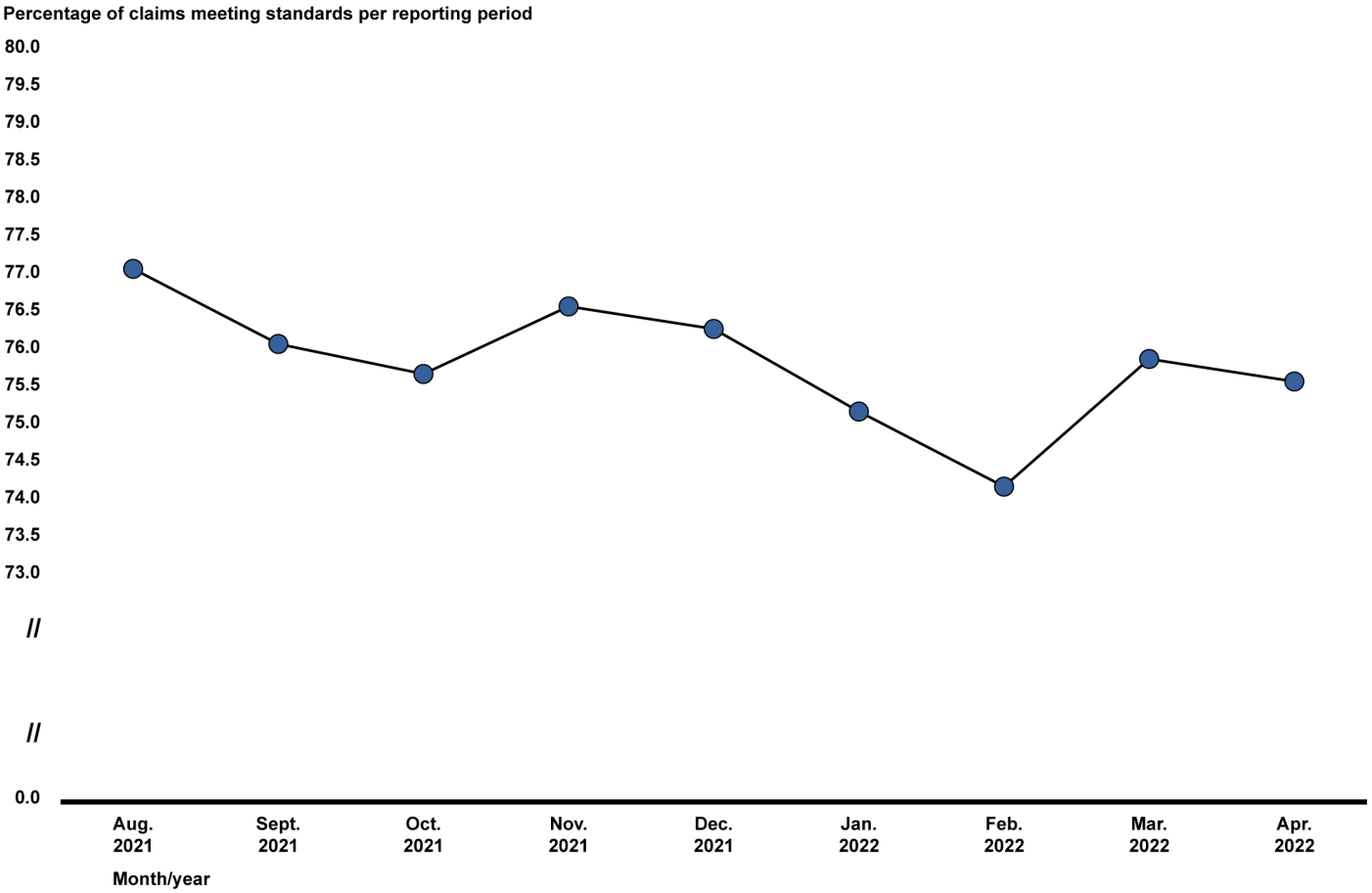


Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 performance report data is a reflection of the claims adjudicated in September 2021. The implementation of CCN Region was completed in June 2020. We reviewed network adequacy performance data starting in August 2020, reflecting July 2020 claims, to ensure the data no longer reflected the implementation phase.

VA's CCN contractor did not begin submitting appointment availability data in their network adequacy performance reports for CCN Region 3 until August 2021. Performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard from August 2021 to April 2022 ranged from 74.2 to 77.1 percent in CCN Region 3. (See fig. 15.)

Figure 15: Community Care Network (CCN) Region 3 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard, August 2021 to April 2022



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor for Region 3 did not begin submitting appointment availability data in their network adequacy performance reports until August 2021. Routine care is care that is not deemed emergent or urgent by the VA ordering provider. Care types included in aggregation are primary care, specialty care, general dental, and specialized dental.

Further analysis of appointment availability performance data found variations in meeting VA's standard among the care types. For example, our analysis of appointment availability performance data found that the majority of claims adjudicated from August 2021 to April 2022 were for routine specialty care. Of the 882,494 claims, performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard ranged from 75.3 to 78.3 percent. (See table 7.)

Table 7: Community Care Network (CCN) Region 3 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard by Care Type, August 2021 to April 2022

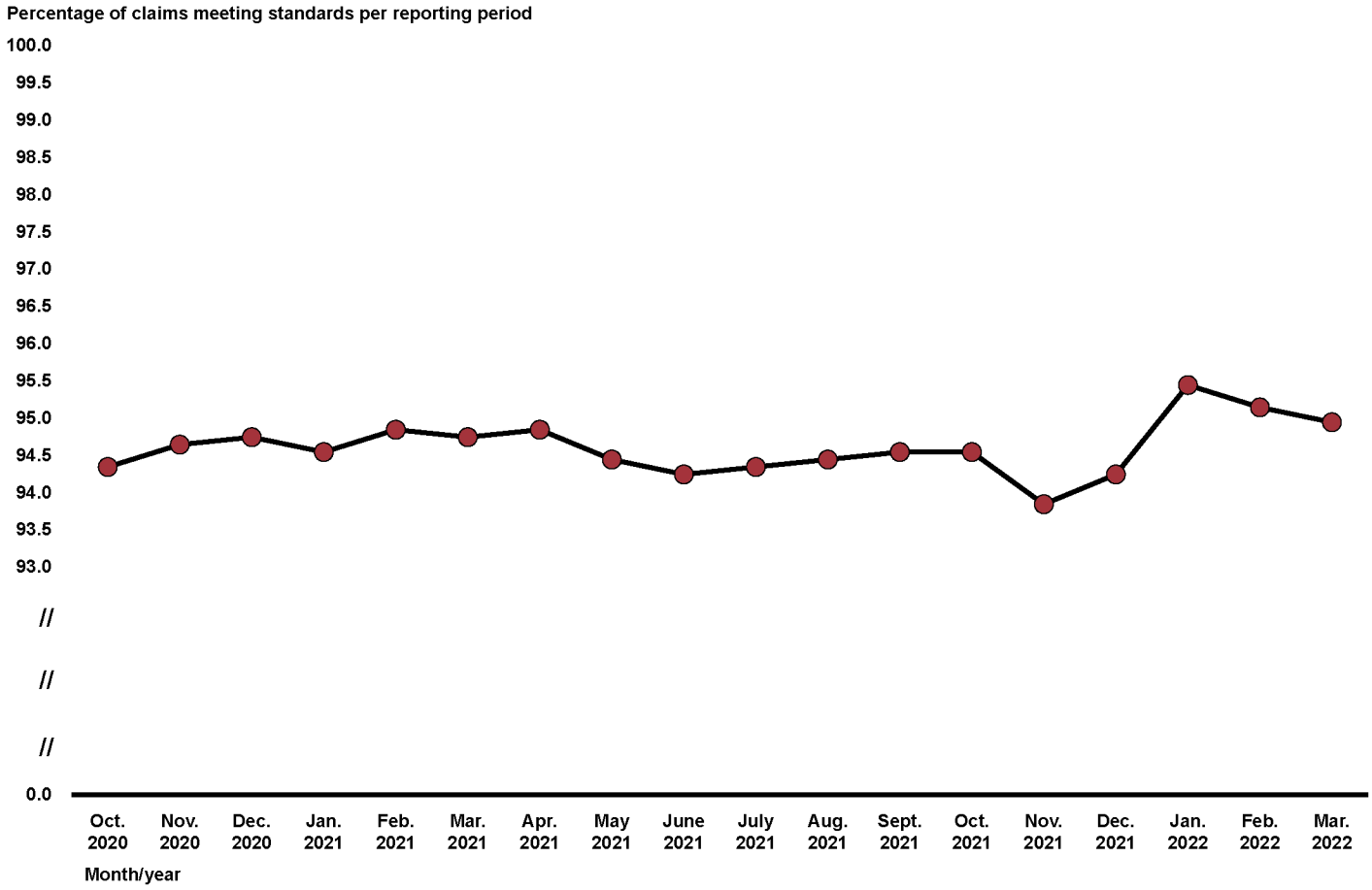
CCN region	Types of care	Total number of claims	Range of percentages of claims that met VA's standard each month
Region 3	Primary care	4,948	46.9 to 53.8
	Specialty care	882,494	75.3 to 78.3
	General dental	5,633	53.8 to 65.0
	Specialized dental	60,535	59.2 to 62.4
	Complementary and integrative health services	3,092	70.1 to 88.8

Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: VA's CCN contractor for Region 3 did not begin submitting appointment availability data in their network adequacy performance reports until August 2021. Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

CCN Region 4. The implementation of CCN Region 4 was completed in August 2020. We reviewed network adequacy performance data for both drive time and appointment availability starting in October 2020, reflecting September 2020 claims, to ensure the data no longer reflected the implementation phase. Performance report data showed that the monthly percentage of claims that met VA's drive-time standard from October 2020 to March 2022 ranged from 93.9 to 95.5 percent in CCN Region 4. (See fig. 16.)

Figure 16: Community Care Network (CCN) Region 4 Aggregated Network Adequacy Performance Report Data Compared against VA's Drive-time Standard, October 2020 to March 2022



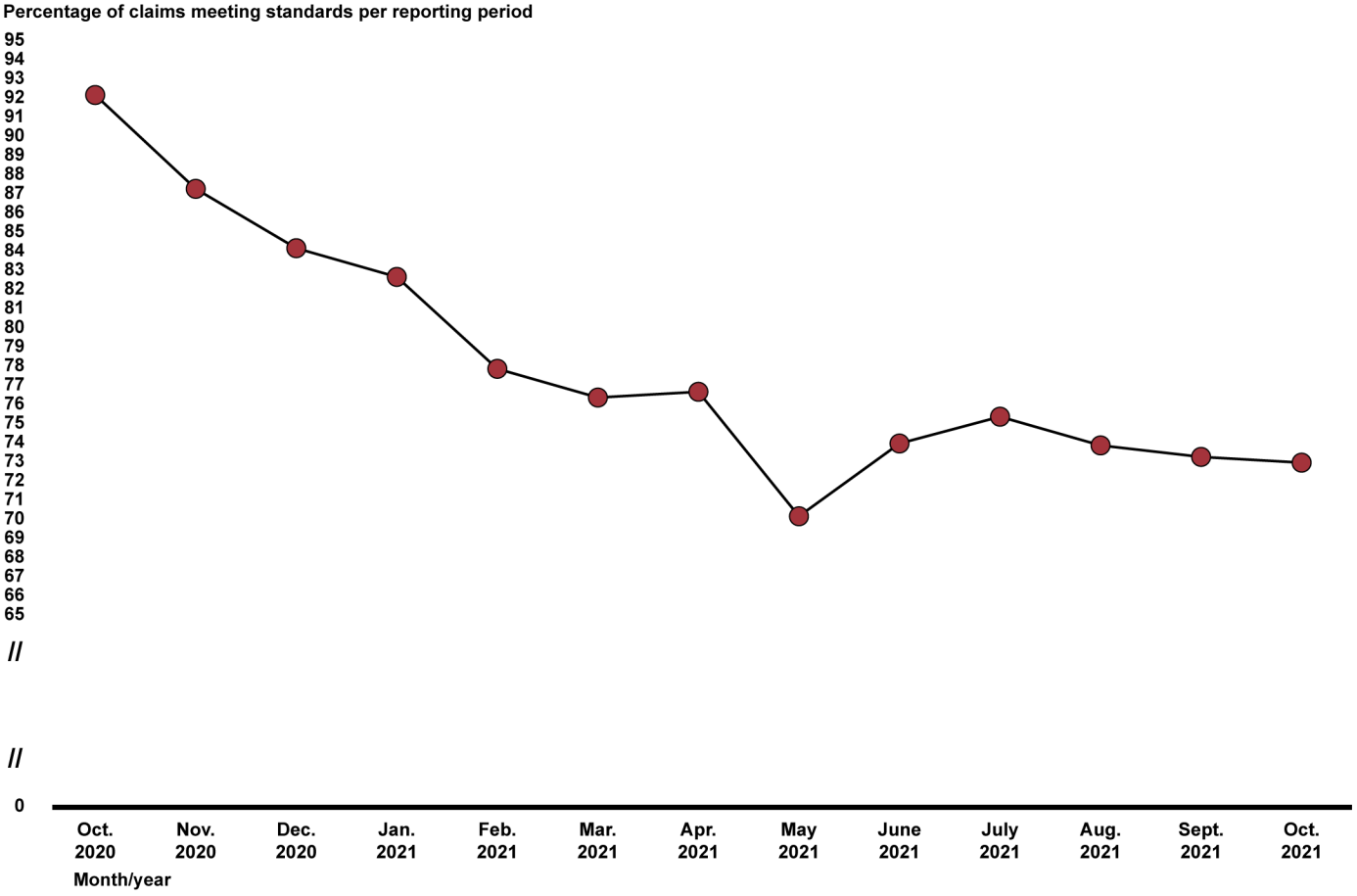
Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 network adequacy report data is a reflection of the claims adjudicated in September 2021. The implementation of CCN Region 4 was completed in August 2020. We reviewed network adequacy performance data starting in October 2020, reflecting September 2020 claims, to ensure the data no longer reflected the implementation phase.

Due to variations in how the network adequacy performance reports were structured in CCN Region 4 from October 2020 to March 2022, we chose to separately report Region 4's appointment availability performance report data into two time frames—October 2020 to October 2021 and November 2021 to March 2022 because the contractor chose to reformat their performance reports by separating the data for the care types into primary care, specialty care, general dental, and specialized dental. Performance report data showed that the monthly percentage of claims

that met VA's routine appointment availability standard from October 2020 to October 2021 ranged from 70.2 to 92.2 percent in CCN Region 4. (See fig. 17.)

Figure 17: Community Care Network (CCN) Region 4 Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard, Oct. 2020 to Oct. 2021



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 network adequacy report data is a reflection of the claims adjudicated in September 2021. Routine care is care that is not deemed emergent or urgent by the VA ordering provider. Care types included in aggregation are primary care, specialty care, general dental, and specialized dental.

Further analysis of appointment availability performance data found variations in meeting VA's standard among the care types. For example, our analysis of appointment availability performance data found that the majority of claims adjudicated from October 2020 to October 2021 were

for routine primary and specialty care. Of the 1,576,701 claims, performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard ranged from 70.3 to 92.5 percent. (See table 8.)

Table 8: Community Care Network (CCN) Region 4 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard by Care Type, October 2020 to October 2021

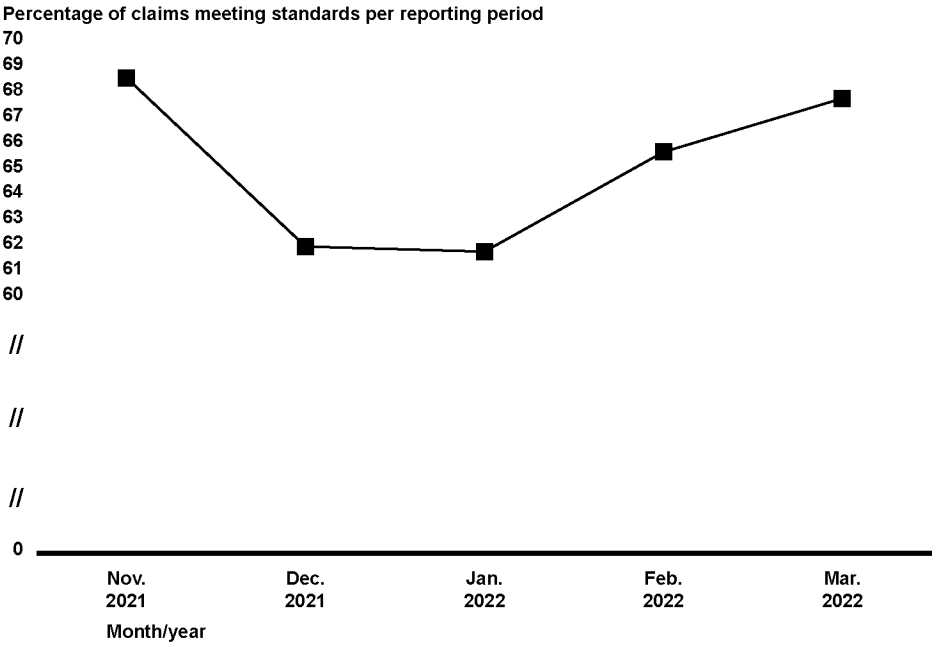
CCN region	Types of care	Total number of claims	Range of percentages of claims that met VA's standard each month
Region 4	Primary and specialty care	1,576,701	70.3 to 92.5
	Dental care	54,872	58.2 to 86.7
	Complementary and integrative health services	1,378	25.0 to 83.3

Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 network adequacy report data is a reflection of the claims adjudicated in September 2021. Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

Performance report data show that the monthly percentage of claims that met VA's routine appointment availability standard from November 2021 to March 2022 ranged from 61.8 to 68.6 percent in CCN Region 4 after network adequacy performance reports were re-formatted to separate primary and general health care services and dental care into two categories – general dental and specialized dental. (See fig. 18.)

Figure 18: Community Care Network (CCN) Region 4 Network Adequacy Performance Report Data Compared against VA's Appointment Availability Standard, November 2021 to March 2022



Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 network adequacy report data is a reflection of the claims adjudicated in September 2021. Routine care is care that is not deemed emergent or urgent by the VA ordering provider. Care types included in aggregation are primary care, specialty care, general dental, and specialized dental.

Further analysis of appointment availability performance data found variations in meeting VA's standard among the care types. For example, our analysis of appointment availability performance data found that the majority of claims adjudicated from November 2021 to March 2022 were for routine specialty care. Of the 573,998 claims, performance report data showed that the monthly percentage of claims that met VA's routine appointment availability standard ranged from 62.1 to 69.3 percent. (See table 9.)

Table 9: Community Care Network (CCN) Region 4 Aggregated Network Adequacy Performance Report Data Compared against VA's Routine Appointment Availability Standard by Care Type, November 2021 to March 2022

CCN region	Types of care	Total number of claims	Range of percentages of claims that met VA's standard each month
Region 4	Primary care	11,115	30.2 to 48.8
	Specialty care	573,998	62.1 to 69.3
	General dental	32,963	62.7 to 66.7
	Specialized dental	3,247	63.1 to 69.6
	Complementary and integrative health services	3,213	56.6 to 88.4

Source: GAO analysis of Department of Veterans Affairs (VA) network adequacy performance reports. | GAO-23-105290

Notes: Network adequacy performance report data is based on the previous month's adjudicated claims. For example, the October 2021 network adequacy report data is a reflection of the claims adjudicated in September 2021. Complementary and integrative health services includes services such as biofeedback, massage therapy, Native American healing, and relaxation techniques. Routine care is care that is not deemed emergent or urgent by the VA ordering provider.

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Appendix IV: Responses to GAO's Survey of VA Medical Facilities

The Department of Veterans Affairs (VA) established five regional networks of community providers, known as Community Care Networks (CCN), to deliver health care services to veterans when they have issues accessing care at VA medical facilities. Two contractors are responsible for maintaining the CCN provider networks, known as CCN Regions 1-5, and ensuring they are adequate in size, scope, and capacity to ensure veterans receive timely access to care. Within the CCN contracts, VA defined two consistent primary standards across CCN Regions 1-4 to determine network adequacy—maximum distances veterans may drive to community providers, and maximum wait times for appointments.[1]

To obtain information about appointment availability in the CCNs, we developed and deployed a survey to all 138 VA medical facilities in Regions 1-4 for which the two contractors report network adequacy data. We pretested the survey with seven VA community care staff at three different VA medical facilities and revised the questions based on their feedback. We administered the survey between February 28 and April 22, 2022 and received responses from officials who oversee the Veterans Community Care Program at 127 VA medical facilities, for a survey response rate of 92 percent.[2] The survey asked respondents about their facilities' experiences in the previous month and covered topics including how far into the future community care officials scheduled initial appointments with CCN providers, provider availability, and challenges with scheduling appointments and using VA's Provider Profile Management System (PPMS). PPMS is VA's database of community providers. The survey also included open-ended questions about working with the two CCN contractors and challenges with appointment availability.

To provide a more complete understanding of VA medical facilities' experience in scheduling appointments, in this appendix we present summary information on the 127 medical facilities' officials' responses to categorical questions about appointment availability, challenges with appointment availability, and using PPMS. We do not include respondents' narrative responses to open-ended questions in this

[1]Our review focused on Regions 1-4, and did not review Region 5 due to the inconsistency in network adequacy standards.

[2]Of the 138 VA medical facilities we contacted, 135 were VA health care systems or VA medical centers, one was a Multi-Specialty Community-Based Outpatient Center, one was an outpatient clinic, and one was a federal healthcare facility that combines VA and Department of Defense medical care in one facility.

appendix. While the survey represents 92 percent of the VA medical facilities for which community care network adequacy data is reported in Regions 1-4, results may not be generalizable to facilities that did not respond to the survey or the facilities in other CCN regions. Further, survey results only represent one point in time.[3]

We asked our survey questions and analyzed VA medical facility responses by service care type. Services provided under the CCN include

- medical services, which cover primary care and specialty care, with specialty care consisting of services such as mental health, cardiology, and gastroenterology;
- complementary and integrative health services (CIHS), such as biofeedback, massage therapy, Native American healing, and relaxation techniques; and
- dental services (for eligible veterans), which comprise both general dental (e.g., exams, cleanings) and specialized dental (e.g., endodontics, periodontics).[4]

For the purposes of this report, we break "medical services" into primary care, specialty care, and mental health services.

For some responses, we provide a breakdown of VA medical facilities' responses by Region or by patient rurality. We defined a VA medical facility as managing care for 50 percent or fewer rural patients or greater than 50 percent rural patients using Unique Urban/Rural Patients data obtained from VA. (See tables 10 through 16.)

[3]Our survey questions asked VA medical facilities to consider appointment availability over the previous month. We asked VA medical facilities how appointment availability over the previous month compared to appointment availability in the past three months. 74 percent of facilities responded that appointment availability over the previous month generally reflected appointment availability over the past three months. 14 percent responded that appointment availability improved and 11 percent responded that appointment availability decreased compared to the last three months.

[4]The CCN contracts provide for other services, like urgent care and pharmacy, but are outside the scope of this review.

Table 10: Community Care Network (CCN) Provider Appointment Availability within 30 Calendar Days for Initial Appointments by Care Type as Reported by VA Medical Facility Officials

	Never	Rarely	Sometimes	Often	Always	Unsure
			Percent indicating			
Primary care	0.79	12.6	23.62	36.22	17.32	9.45
Mental health	7.09	37.8	29.13	18.11	7.09	0.79
Specialty care	1.57	17.32	46.46	31.5	3.15	0
CIHS	1.57	10.24	24.41	44.09	14.17	5.51
General dental	3.15	24.41	32.28	29.92	7.09	3.15
Specialized dental	5.51	31.5	36.22	16.54	5.51	4.72

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Note: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. Percentages may not sum to 100 percent due to rounding.

Table 11: Number of Calendar Days from the Clinically Indicated Date That More than Half of Initial Appointments Were Scheduled by Care Type as Reported by VA Medical Facility Officials

	0-14 days	15-30 days	31-45 days	>45 days	Unsure	No response
			Percent indicating			
Primary care	16.54	34.65	22.83	10.24	14.96	0.79
Mental health	13.39	22.83	33.07	25.2	4.72	0.79
Specialty care	7.09	27.56	37.8	22.05	4.72	0.79
CIHS	26.77	29.13	21.26	8.66	13.39	0.79
General dental	9.45	27.56	33.86	20.47	7.87	0.79
Specialized dental	8.66	19.69	26.77	34.65	9.45	0.79

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. The clinically indicated date is the date an appointment is deemed clinically appropriate by the referring VA provider. Percentages may not sum to 100 percent due to rounding.

Table 11a. Number of Calendar Days from the Clinically Indicated Date That More than Half of Initial Appointments Were Scheduled, by Care Type and Community Care Network (CCN) Region as Reported by VA Medical Facility Officials

	CCN Region 1 (N=37)					
	0-14 days	15-30 days	31-45 days	>45 days	Unsure	
	Percent indicating					
Primary care	18.92	24.32	18.92	10.81	27.03	
Mental health	13.51	13.51	29.73	37.84	5.41	
Specialty care	5.41	35.14	27.03	29.73	2.7	
CIHS	21.62	27.03	29.73	10.81	10.81	
General dental	8.11	18.92	29.73	35.14	8.11	
Specialized dental	8.11	13.51	24.32	45.95	8.11	
	CCN Region 2 (N=35)					
	0-14 days	15-30 days	31-45 days	>45 days	Unsure	
	Percent indicating					
Primary care	20	45.71	20	2.86	11.43	
Mental health	14.29	34.29	25.71	20	5.71	
Specialty care	11.43	40	28.57	11.43	8.57	
CIHS	31.43	34.29	5.71	11.43	17.14	
General dental	11.43	37.14	25.71	11.43	14.29	
Specialized dental	11.43	31.43	20	22.86	14.29	
	CCN Region 3 (N=21)					
	0-14 days	15-30 days	31-45 days	>45 days	Unsure	No response
	Percent Indicating					
Primary care	19.05	42.86	14.29	14.29	4.76	4.76
Mental health	19.05	28.57	38.1	9.52	0	4.76
Specialty care	9.52	9.52	61.9	14.29	0	4.76
CIHS	38.1	28.57	9.52	9.52	9.52	4.76
General dental	4.76	28.57	38.1	23.81	0	4.76
Specialized dental	0	14.29	38.1	33.33	9.52	4.76
	CCN Region 4 (N=34)					
	0-14 days	15-30 days	31-45 days	>45 days	Unsure	
	Percent indicating					
Primary care	8.82	29.41	35.29	14.71	11.76	
Mental health	8.82	17.65	41.18	26.47	5.88	
Specialty care	2.94	17.65	44.12	29.41	5.88	
CIHS	20.59	26.47	35.29	2.94	14.71	
General dental	11.76	26.47	44.12	11.76	5.88	
Specialized dental	11.76	17.65	29.41	35.29	5.88	

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. The clinically indicated date is the date an appointment is deemed clinically appropriate by the referring VA provider. Percentages may not sum to 100 percent due to rounding.

Table 11b: Number of Calendar Days from the Clinically Indicated Date that More than Half of Initial Appointments Were Scheduled, by Care Type and Patient Rurality as Reported by VA Medical Facility Officials

Care type	Patient rurality of VA medical facility	0-14 days	15-30 days	31-45 days	>45 days	Unsure	No response
		Percent indicating					
Primary care	50% or fewer rural patients	17.58	32.97	21.98	9.89	16.48	1.1
	>50% rural patients	13.89	38.89	25	11.11	11.11	0
Mental health	50% or fewer rural patients	9.89	18.68	35.16	29.67	5.49	1.1
	>50% rural patients	22.22	33.33	27.78	13.89	2.78	0
Specialty care	50% or fewer rural patients	7.69	27.47	34.07	24.18	5.49	1.1
	>50% rural patients	5.56	27.78	47.22	16.67	2.78	0
CIHS	50% or fewer rural patients	27.47	26.37	24.18	5.49	15.38	1.1
	>50% rural patients	25	36.11	13.89	16.67	8.33	0
General dental	50% or fewer rural patients	9.89	28.57	32.97	18.68	8.79	1.1
	>50% rural patients	8.33	25	36.11	25	5.56	0
Specialty dental	50% or fewer rural patients	8.79	19.78	26.37	34.07	9.89	1.1
	>50% rural patients	8.33	19.44	27.78	36.11	8.33	0

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: 90 VA medical facilities responding to this survey were facilities with 50 percent or fewer rural patients. 36 were facilities with >50 percent rural patients. Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. The clinically indicated date is the date an appointment is deemed clinically appropriate by the referring VA provider. Percentages may not sum to 100 percent due to rounding.

Table 12: Community Care Network (CCN) Provider Types with the Least Availability for Initial Appointments within 30 Calendar Days of the Clinically Indicated Date as Reported by VA Medical Facility Officials

CCN Provider Type	Number of VA medical facilities indicating least appointment availability	Percent of VA medical facilities indicating least appointment availability
Mental health	80	62.99
Gastroenterology	68	53.54
Neurology	67	52.76
Rheumatology	52	40.94
Dermatology	51	40.16

CCN Provider Type	Number of VA medical facilities indicating least appointment availability	Percent of VA medical facilities indicating least appointment availability
Endocrinology	51	40.16
Pulmonology	49	38.58
Urology	44	34.65
Pain management	38	29.92
Cardiology	34	26.77
Orthopedic	32	25.2
Ophthalmology	30	23.62
Gynecology/Infertility/Maternity	26	20.47
General surgery	24	18.9
Podiatry	17	13.39
Home health care	16	12.6
Radiology/Imaging	16	12.6
Geriatric and extended care	14	11.02
Acupuncture	12	9.45
Chiropractic	10	7.87
Physical therapy	10	7.87
General dental	9	7.09
Sleep	6	4.72
Ear, Nose, and Throat	5	3.94
Neurosurgery	5	3.94
Complementary and Integrative Health Services	4	3.15
Specialty dental	3	2.36
Nephrology	3	2.36
Infectious disease	2	1.57
Transplant	2	1.57
Genetic testing	2	1.57
Wound care	1	0.79
Plastic surgery	1	0.79
Gender affirming care	1	0.79
Audiology	1	0.79
Substance use disorder treatment	1	0.79
Vascular	1	0.79
Hematology	1	0.79

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Total responses = 125. Facilities could select more than one response and provide additional responses in a text box field labeled "other." The "other" responses have been incorporated into this list of provider types.

Table 13: Factors Significantly Impacting Scheduling of Initial Appointments with Community Care Network (CCN) Providers within 30 Days by Care Type as Reported by VA Medical Facility Officials

	Not enough providers in CCN	Limited appointment availability due to COVID-19	Limited appointment availability (not due to COVID-19)	Veteran preference for a specific date or provider	Other	No challenges	No response
	Percent indicating						
Primary care	19.69	8.66	14.17	10.24	16.54	47.24	0.79
Mental health	57.48	20.47	35.43	24.41	12.6	11.02	0.79
Specialty care	33.07	33.07	47.24	14.17	13.39	8.66	1.57
CIHS	29.92	11.02	14.17	8.66	12.6	40.94	2.36
General dental	40.94	16.54	22.05	14.17	17.32	23.62	0.79
Specialized dental	63.78	17.32	25.98	9.45	14.17	9.45	0.79

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. Facilities could select more than one response and provide additional responses in a text box field labeled "other." Percentages may not sum to 100 percent due to rounding.

Table 13a: Factors Significantly Impacting Scheduling of Initial Appointments with Community Care Network (CCN) Providers within 30 Days, by Region as Reported by VA Medical Facility Officials

	CCN Region 1 (N=37)						
	Not enough providers in CCN	Limited appointment availability due to COVID-19	Limited appointment availability (not due to COVID-19)	Veteran preference for a specific date or provider	Other	No challenges	No response
	Percent indicating						
Primary care	18.92	10.81	10.81	10.81	13.51	51.35	2.7
Mental health	56.76	18.92	35.14	27.03	8.11	13.51	2.7
Specialty care	37.84	37.84	35.14	21.62	13.51	5.41	2.7
CIHS	35.14	13.51	16.22	10.81	10.81	37.84	2.7
General dental	43.24	24.32	29.73	16.22	13.51	16.22	2.7
Specialized dental	56.76	24.32	29.73	10.81	10.81	10.81	2.7

	Not enough providers in CCN	Limited appointment availability due to COVID-19	Limited appointment availability (not due to COVID-19)	Veteran preference for a specific date or provider	Other	No challenges	No response
CCN Region 2 (N=35)							
	Percent indicating						
Primary care	8.57	0	14.29	5.71	11.43	65.71	0
Mental health	51.43	14.29	31.43	20	8.57	5.71	0
Specialty care	17.14	37.14	48.57	8.57	8.57	14.29	0
CIHS	22.86	5.71	8.57	8.57	11.43	48.57	2.86
General dental	28.57	11.43	14.29	14.29	20	28.57	0
Specialized dental	62.86	11.43	14.29	2.86	20	5.71	0
CCN Region 3 (N=21)							
	Not enough providers in CCN	**Limited appointment availability due to COVID-19**	**Limited appointment availability (not due to COVID-19)**	**Veteran preference for a specific date or provider**	**Other**	**No challenges**	**No response**
	Percent indicating						
Primary care	14.29	19.05	14.29	4.76	19.05	42.86	0
Mental health	47.62	23.81	33.33	14.29	19.05	23.81	0
Specialty care	19.05	19.05	47.62	14.29	14.29	14.29	4.76
CIHS	23.81	4.76	14.29	4.76	9.52	47.62	0
General dental	38.1	4.76	19.05	14.29	19.05	28.57	0
Specialized dental	52.38	9.52	23.81	14.29	19.05	14.29	0
CCN Region 4 (N=34)							
	Not enough providers in CCN	**Limited appointment availability due to COVID-19**	**Limited appointment availability (not due to COVID-19)**	**Veteran preference for a specific date or provider**	**Other**	**No challenges**	**No response**
	Percent indicating						
Primary care	35.29	8.82	17.65	17.65	23.53	26.47	0
Mental health	70.59	26.47	41.18	32.35	17.65	5.88	0
Specialty care	52.94	32.35	58.82	11.76	17.65	2.94	0
CIHS	35.29	17.65	17.65	8.82	17.65	32.35	2.94
General dental	52.94	20.59	23.53	11.76	17.65	23.53	0
Specialized dental	79.41	20.59	35.29	11.76	8.82	8.82	0

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. Facilities could select more than one

response and provide additional responses in a text box field labeled "other." Percentages may not sum to 100 percent due to rounding.

Table 14: Percent of VA Medical Facilities with Sufficient Scheduling Staff to Manage Community Care Appointment Scheduling as Reported by VA Medical Facility Officials

	Not at all	Slightly	Moderately	Greatly	Completely
Percent of VA medical facilities	18.9	28.35	33.07	14.17	5.51

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Note: Percentages may not sum to 100 percent due to rounding.

Table 15: Extent to Which the Provider Profile Management System (PPMS) Accurately Reflected Community Care Network (CCN) Providers Available to See Veterans by Care Type, as Reported by VA Medical Facility Officials

	Not at all	Slightly	Moderately	Greatly	Completely	Unsure
	Percent indicating					
Primary care	6.3	16.54	21.26	31.5	11.02	13.39
Mental health	11.81	28.35	27.56	20.47	6.3	5.51
Specialty care	5.51	25.2	37.8	20.47	6.3	4.72
CIHS	10.24	18.11	30.71	25.2	7.09	8.66
General dental	10.24	25.2	28.35	21.26	7.87	7.09
Specialized dental	12.6	27.56	29.13	15.75	7.09	7.87

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. PPMS is VA's database of community providers. Percentages may not sum to 100 percent due to rounding.

Table 15a: Extent to Which the Provider Profile Management System (PPMS) Accurately Reflected Community Care Network (CCN) Providers Available to See Veterans, By CCN Region, as Reported by VA Medical Facility Officials

	CCN Region 1 (N=37)					
	Not at all	Slightly	Moderately	Greatly	Completely	Unsure
	Percent indicating					
Primary care	8.11	10.81	8.11	32.43	13.51	27.03
Mental health	16.22	24.32	21.62	24.32	5.41	8.11
Specialty care	5.41	24.32	27.03	29.73	5.41	8.11
CIHS	10.81	16.22	32.43	24.32	5.41	10.81
General dental	8.11	21.62	27.03	24.32	8.11	10.81
Specialized dental	8.11	21.62	29.73	21.62	8.11	10.81

	CCN Region 2 (N=35)					
	Not at all	Slightly	Moderately	Greatly	Completely	Unsure
	Percent indicating					
Primary care	0	11.43	31.43	40	11.43	5.71
Mental health	5.71	28.57	34.29	22.86	5.71	2.86
Specialty care	0	22.86	42.86	22.86	8.57	2.86
CIHS	2.86	11.43	37.14	34.29	5.71	8.57
General dental	5.71	17.14	40	22.86	8.57	5.71
Specialized dental	11.43	20	37.14	17.14	8.57	5.71
	CCN Region 3 (N=21)					
	Not at all	Slightly	Moderately	Greatly	Completely	Unsure
	Percent indicating					
Primary care	9.52	33.33	14.29	23.81	14.29	4.76
Mental health	9.52	33.33	23.81	19.05	14.29	0
Specialty care	9.52	38.1	23.81	19.05	9.52	0
CIHS	19.05	23.81	19.05	23.81	14.29	0
General dental	14.29	28.57	28.57	14.29	14.29	0
Specialized dental	14.29	33.33	23.81	14.29	9.52	4.76
	Region 4 (N=34)					
	Not at all	Slightly	Moderately	Greatly	Completely	Unsure
	Percent indicating					
Primary care	8.82	17.65	29.41	26.47	5.88	11.76
Mental health	14.71	29.41	29.41	14.71	2.94	8.82
Specialty care	8.82	20.59	52.94	8.82	2.94	5.88
CIHS	11.76	23.53	29.41	17.65	5.88	11.76
General dental	14.71	35.29	17.65	20.59	2.94	8.82
Specialized dental	17.65	38.24	23.53	8.82	2.94	8.82

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. PPMS is VA's database of community providers. Percentages may not sum to 100 percent due to rounding.

Table 16: Problems VA Medical Facilities Encounter in the Provider Profile Management System (PPMS) When Scheduling Appointments with Community Care Network (CCN) Providers, by Care Type as Reported by VA Medical Facility Officials

	Primary Care (N=56)					
	Never	Rarely	Sometimes	Often	Always	No response
	Percent indicating					
Provider is not aware they are enrolled in the CCN	8.93	33.93	41.07	14.29	0	1.79
Provider is no longer accepting veterans	5.36	16.07	37.5	39.29	0	1.79
Provider is not accepting any new patients, regardless of veteran status	5.36	14.29	42.86	35.71	0	1.79
Provider information in PPMS is incomplete or inaccurate	1.79	17.86	30.36	41.07	7.14	1.79
	Mental Health (N=86)					
	Never	Rarely	Sometimes	Often	Always	No response
	Percent indicating					
Provider is not aware they are enrolled in the CCN	8.14	31.4	34.88	23.26	0	2.33
Provider is no longer accepting veterans	1.16	6.98	47.67	39.53	2.33	2.33
Provider is not accepting any new patients, regardless of veteran status	1.16	8.14	45.35	40.7	2.33	2.33
Provider information in PPMS is incomplete or inaccurate	1.16	16.28	41.86	33.72	3.49	3.49
	Specialty Care (N=87)					
	Never	Rarely	Sometimes	Often	Always	No response
	Percent indicating					
Provider is not aware they are enrolled in the CCN	3.45	28.74	45.98	19.54	1.15	1.15
Provider is no longer accepting veterans	1.15	12.64	50.57	31.03	2.3	2.3
Provider is not accepting any new patients, regardless of veteran status	0	25.29	49.43	21.84	2.3	1.15
Provider information in PPMS is incomplete or inaccurate	1.15	21.84	40.23	32.18	3.45	1.15

	Never	Rarely	Sometimes	Often	Always	No response
Complementary and Integrative Health Services (N=75)						
	Percent indicating					
Provider is not aware they are enrolled in the CCN	6.67	41.33	30.67	14.67	2.67	4
Provider is no longer accepting veterans	5.33	29.33	40	17.33	4	4
Provider is not accepting any new patients, regardless of veteran status	5.33	32	45.33	10.67	2.67	4
Provider information in PPMS is incomplete or inaccurate	4	30.67	42.67	13.33	5.33	4
General Dental (N=81)						
	Never	**Rarely**	**Sometimes**	**Often**	**Always**	**No response**
	Percent indicating					
Provider is not aware they are enrolled in the CCN	11.11	39.51	28.4	18.52	1.23	1.23
Provider is no longer accepting veterans	3.7	19.75	27.16	45.68	2.47	1.23
Provider is not accepting any new patients, regardless of veteran status	7.41	24.69	35.8	27.16	2.47	2.47
Provider information in PPMS is incomplete or inaccurate	2.47	28.4	37.04	25.93	3.7	2.47
Specialized Dental (N=88)						
	Never	**Rarely**	**Sometimes**	**Often**	**Always**	**No response**
	Percent indicating					
Provider is not aware they are enrolled in the CCN	7.95	29.55	27.27	19.32	1.14	14.77
Provider is no longer accepting veterans	2.27	12.5	31.82	34.09	4.55	14.77
Provider is not accepting any new patients, regardless of veteran status	4.55	22.73	32.95	21.59	3.41	14.77
Provider information in PPMS is incomplete or inaccurate	2.27	22.73	28.41	29.55	2.27	14.77

Source: GAO analysis of survey of officials from 127 Department of Veterans Affairs (VA) medical facilities administered between February and April, 2022. | GAO-23-105290

Notes: Facilities that indicated issues with PPMS accuracy by care type (i.e. ratings of "not at all," "slightly," or "moderately" displayed in table 15) were further asked to evaluate examples of issues related to PPMS accuracy. Complementary and integrative health services (CIHS) includes services such as biofeedback, massage, Native American healing, and relaxation techniques. PPMS is VA's database of community providers. Percentages may not sum to 100 percent due to rounding.

Appendix V: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON

October 21, 2022

Ms. Sharon Silas
Director
Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Silas:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VETERANS COMMUNITY CARE PROGRAM: VA Needs to Strengthen Its Oversight and Improve Data On Its Community Care Network Providers*** (GAO-23-105290).

The enclosure contains general and technical comments and the action plan to implement the draft report recommendations. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Tanya J. Bradsher
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
VETERANS COMMUNITY CARE PROGRAM: VA Needs to Strengthen Its Oversight and Improve Data on Its Community Care Network Providers
(GAO-23-105290)

Recommendation 1: The Under Secretary for Health should ensure that the contractors report complete claims data when calculating performance against VA's network adequacy standards. In cases where VA has made agreements with the contractors to exclude certain claims, those reasons should be clearly documented by VA.

VA Response: Concur. The adequacy of the Community Care Network (CCN) is a priority of VA's Office of Integrated Veteran Care (IVC). IVC has worked to ensure the data in Network Adequacy deliverables are complete and will continue to review the data to ensure both IVC and the contractor are monitoring the network. Optum began including appointment timeliness data in the Network Adequacy deliverable in August of 2021. During October 2022, TriWest began including all applicable failed claims into the calculation for network adequacy. In cases where VA has agreed to exclusion of claims, IVC has documented these agreed upon exclusions within the contract and associated Quality Assurance Surveillance Plan.

To ensure CCN adequacy, IVC developed the capability to monitor network adequacy independently, and this is now available through the Network Management dashboard within the Advanced Medical Cost Management Solution (AMCMS) system. This evaluation of the AMCMS data alleviates the need for dependence on contractor-reported data. IVC is on target to implement the full process of review and validation of the complete data being reported by the Third-Party Administrators, while comparing to the AMCMS data, by the next Performance Management Review meetings occurring at the end of this calendar year.

Target Completion Date: January 2023

Recommendation 2: The Under Secretary review its processes for monitoring the accuracy and completeness of contractor-submitted provider data in PPMS and implement strategies under current or future contracts to increase the accuracy of provider information stored in PPMS. For example, VA could require the contractors to use proactive processes to ensure data accuracy.

VA Response: Concur. To improve the accuracy and completeness of contractor submitted provider data in the Provider Profile Management System (PPMS), VA requested enhancements to PPMS that would create functionality for reporting provider demographic errors (e.g., incorrect address, phone number) directly in the PPMS system. Once completed, the new functionality will allow the field to document errors identified in PPMS and use the corrected data for provider location and referral data population. To ensure TPAs are aware of identified errors, VA will submit the reported

Enclosure

Department of Veterans Affairs (VA) Comments to
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(GAO-23-105290)

information to the appropriate contractor with the expectation they review and reply with actions taken to correct the identified errors.

IVC will develop a review process to allow for proactive identification of provider data errors. The process will focus on analysis of provider data submitted by the TPAs and identification of potential errors. These errors will be reported to the TPAs with the expectation that they review and reply with actions taken to correct the identified errors.

Target Completion Date: January 2023

Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contact

Sharon M. Silas, (202) 512-7114 or silass@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Kate Tussey (Analyst-in-Charge), Emily Binek, Kelly Husted, Cynthia Khan, Nicholas Lessard-Chaudoin, and Phillip Steinberg made key contributions to this report. Also contributing were Jennie Apter, Jacquelyn Hamilton, Vikki Porter, and Roxanna Sun.

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