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STATEMENT OF
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ACTING DEPUTY UNDER SECRETARY FOR OPERATIONS AND MANAGEMENT
VETERANS HEALTH ADMINISTRATION
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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Mr. Chairman, Ranking Member, and members of the Committee: Thank you for providing me this opportunity to discuss the Department of Veterans Affairs' (VA) oversight of health care organizations contracting with VA to provide health services to Veterans. I am accompanied today by Jan Frye, Deputy Assistant Secretary for Acquisition and Logistics, Department of Veterans Affairs; Fred Downs, Chief Procurement and Logistics Officer, Veterans Health Administration; Patricia Gheen, Deputy Chief Business Officer for Purchased Care, Chief Business Office, Veterans Health Administration; and Bradley Mayes, Director of the Compensation and Pension Service, Veterans Benefits Administration.

VA provides care to Veterans directly in a VA medical center or indirectly through either fee-basis care or through contracts with local providers. This strategic mix of in-house and external care provides Veterans the full continuum of health care services covered under our benefits package. My testimony today will focus on VA's oversight of health care organizations contracting with VA to provide health services to Veterans, VA's obligations and procedures for ensuring quality care through contracts, VA's Project on Healthcare Effectiveness through Resource Optimization (Project HERO), oversight of compensation and pension examinations conducted by QTC Management, Inc., and other large-scale contracts.

Oversight of Health Care Contracts

All VA health care resource contracting is accomplished under the provisions of VA Directive 1663, "Health Care Resources Contracting." VA's Directive 1663 further implements provisions of Public Law 104-262, "The Veterans Health Care Eligibility Reform Act of 1996," which significantly expanded VA's health care resources sharing authority in title 38 United States Code (U.S.C.) sections 8151 through 8153.

VA medical center directors determine when additional health care resources are required. It is the policy of the Veterans Health Administration (VHA) to provide Veterans care within the VA health care system, whenever feasible.

When VA is unable to provide care within the system, for example because a qualified clinician cannot be recruited the medical center director must first consider sending patients to another VA medical center. Contracting for necessary services will only be considered if these options are not appropriate or viable. If contracting for services is required, a competitive bid is the first option to be considered.

There are two principal avenues to contract for health care services: conventional commercial

providers and academic affiliates. VA's academic affiliates (schools of medicine, academic medical centers and their associated clinical practices) provide a large proportion of contracted clinical care both within and outside of VA.

All VA health care resource contracts are reviewed through a thorough process that includes the Office of General Counsel (for legal sufficiency), VHA's Patient Care Services (for quality and safety), VHA's Office of Academic Affiliations (for affiliate relations assessment), and VHA's Procurement and Logistics Office (for acquisition technical review for policy compliance). A formal Medical Sharing Review Committee, consisting of senior executives from those VA organizations, approves or disapproves the concept of contracting for care and provides management oversight of the health care contracting requirements and acquisition process.

Quality Management for Contracted Care

VA retains ultimate responsibility for the quality of care delivered within its facilities to Veterans. VA exercises this responsibility through several clinical and administrative oversight mechanisms, including credentialing and privileging, quality and patient safety monitoring, and the inclusion of specific quality of care provisions in the contract itself.

Quality assurance is a shared responsibility of VA and the vendor. The joint and separate responsibilities of VA and the vendor must be defined in advance so that medical care delivery under a sharing agreement (contract) can be effectively monitored (VA Directive 1663, Health Care Resources Contracting – Buying, Sections 4.d.1 and 4.d.2). The VISN Director is responsible for ensuring that each facility Chief of Staff has appropriate quality assurance standards in place; appropriate data methods have been defined; and data collection, analysis and reporting are performed as specified.

VA Central Office's Sharing Contract Review Committee is responsible for providing an additional level of review, including review of the quality assurance provisions. Within this Committee, VHA's Patient Care Services has primary responsibility for assuring that medical sharing contracts contain appropriate quality and patient safety provisions.

Facility Directors must ensure that these oversight mechanisms are consistently and effectively applied to all in-house contracted care. All contracts for physician services provided at VA must state that credentialing and privileging is to be done in accordance with the provisions of VHA Handbook 1100.19, "Credentialing and Privileging." Facility Service Chiefs are responsible for the quality of care within their clinical disciplines pursuant to VHA Handbook 1100.19 and Joint Commission Standards MS.03.01.01, MS.04.01 .01, LD.04.03.01 and LD.04.03.09. Facility Service Chiefs exercise this responsibility through such actions as oversight of credentialing and privileging, and review of provider-specific data and peer review processes.

The Joint Commission also has specific standards for focused monitoring whenever new procedures or new technology are involved (Joint Commission Standards MS.08.01 .01 and LD. 04.03.01). As noted above, Clinical Service Chiefs and/or the Chief of Staff have primary responsibility for the oversight of quality and safety monitoring.

Quality and safety standards and monitoring procedures will vary as a function of the specific service being provided. However, all applicable VA quality and patient safety standards must be met for medical services provided under contract in a VA facility. Ensuring quality standards for VA-contracted care when services are provided outside of a VA facility is more difficult, but VA includes language in contracts that allows for industry standard accreditation or certification requirements, clinical reporting and oversight. VA also includes clauses that allow it to negotiate additional terms as new clinical requirements are instituted by the Department.

Project on Healthcare Effectiveness through Resource Optimization (Project HERO) Given our desire for patient-centered care and recognizing that it may not always be able to provide Veterans care within our facilities, VA has a continued need for non-VA services. This purchasing of health care services represents a key component in our health care delivery continuum. VA understands the importance of closely managing the services purchased and has initiated multiple efforts around improving that management. Project HERO is a cornerstone of those efforts.
House Report 109-305, the conference report to accompany Public Law 109-114, provided that VA establish at least three managed care demonstration programs to satisfy a set of health care objectives related to arranging and managing care. The conferees supported VA's expeditious implementation of care management strategies that have proven valuable in the broader public and private sectors, and to ensure care purchased for enrollees from community providers is cost-effective and complementary to the larger VA health care system. The conferees encouraged VA to collaborate with industry, academia, and other organizations to incorporate a variety of public-private partnerships.
Project HERO is in year two of a proposed five-year contracting pilot to increase the quality oversight and decrease the cost of purchased (fee) care. It is currently available in four Veterans Integrated Service Networks (VISN): VA Sunshine Healthcare Network (VISN 8), South Central VA Health Care Network (VISN 16), Northwest Network (VISN 20) and VA Midwest Health Care Network (VISN 23). These VISNs have historically had high expenditures for non-VA purchased care (fee care) and substantial Veteran enrollee populations. When VA cannot readily provide the care Veterans need internally, VA medical centers utilize the traditional fee basis program or, in selected VISNs, Project HERO.
Project HERO is one of our most comprehensive pilot programs intended to improve the management and oversight of the purchase of non-VA health care services. It represents a significant and proactive approach to assessing timeliness, quality, and clinical information sharing for purchased care services, resolving potential deficiencies in this area. In Project HERO, VA contracts with Humana Veterans Healthcare Services (HVHS) and Delta Dental Federal Services to provide Veterans with pre-screened networks of doctors and dentists who meet VA quality standards at negotiated contract rates.
Project HERO is predominantly an outpatient program for specialty services such as dental, ophthalmology, physical therapy, and other services not always available in VA. For every patient, VA medical centers determine and authorize the specific services and treatments to Project HERO contracted network doctors and dentists.
Project HERO's demonstration objectives have been shared with a number of key stakeholders, including Veterans Service Organizations, the American Federation of Government Employees, academic affiliates, and industry. The VHA Project HERO Program Management Office presented the following objectives to the House Appropriations Committee and House Veterans' Affairs Committee in the second quarter of 2006:
. Provide as much care for Veterans within VHA as practical;

• Refer Veterans efficiently to high-quality community-based care when necessary;
• Improve the exchange of medical information between VA and non-VA providers;
• Foster high-quality care and patient safety;
• Control operating costs;
• Increase Veteran satisfaction;
• Secure accountable evaluation of demonstration; and

• Sustain partnerships with university Affiliates.

The VHA Chief Business Office oversees purchased care programs, including fee care and Project HERO. This Office meets with internal and external stakeholders and monitors and evaluates program metrics. The Project HERO Governing Board oversees program activities and is composed of the Acting Deputy Under Secretary for Health Operations and Management, the VHA Chief Business Officer, and network directors from the four participating VISNs. The Board also has advisors from General Counsel, the Office of Academic Affiliations, and the Office of Acquisition, Logistics, and Construction.

The Contract Administration Board provides contract guidance as needed and includes contracting and legal representatives. The Project HERO Program Management Office (PMO) oversees the contracts to help ensure quality care, timely access to care, timely return of clinical information to VA, patient safety and satisfaction. The PMO includes contract administration, project management, performance and quality management; data analysis, reporting and auditing; and communication and training.

Project HERO contracts require HVHS and Delta Dental to meet VA standards for:

• Credentialing and accreditation;
• Timely reporting of access to care;
• Timely return of clinical information to VA;
• Reporting patient safety issues, patient complaints and patient satisfaction; and
• Robust quality programs including peer review with VA participation, while meeting Joint Commission and other industry requirements.

Humana Veterans Healthcare Services utilizes the Agency for Health Research and Quality patient safety indicators as well as complaints, referrals and as sources for initiating peer review. The Project HERO PMO monitors contract performance, audits credentialing and accreditation, and evaluates HVHS and Delta Dental performance compared to VA Survey of Healthcare Experiences of Patients (SHEP), Joint Commission measures, and proxy measures based on HEDIS measures. This analysis indicates that Project HERO facilities are equal to or better than the national average for all non-VA hospitals that report to the Joint Commission.

Project HERO has negotiated contract rates with HVHS and Delta Dental. Eighty-nine percent of Project HERO contracted medical prices with HVHS are at or below Medicare rates, and contracted rates with Delta Dental are less than 80 percent of National Dentistry Advisory Service Comprehensive Fee Report for dental services.

While Project HERO is only in the second year of a 5 year pilot, the program is meeting its objectives and improving quality oversight, access, accountability and care coordination. As a demonstration project, VA has gained invaluable experience in developing future health care contracts, managing both the timely delivery of health care and the quality of the care provided. Specifically, VA has found:

• Patient satisfaction is comparable to VA;
• HVHS and Delta Dental providers meet VA quality standards and maintain extensive quality programs. The Project HERO PMO audits for compliance and participates in their quality councils and peer review committees.
• HVHS and Delta Dental provide timely access to care, providing specialty or routine care within 30 days 84 percent and 100 percent of the time respectively.
• Both vendors are contracted to return medical documentation to VA within 30 days for more informed, continuous patient care. The Project HERO PMO

worked with HVHS, Delta Dental and VA medical centers to make electronic clinical information sharing available at all Project HERO sites. Additionally,

These significant improvements, gained through Project HERO, have resulted in a more robust oversight of these key programs. While VHA recognizes the continuous need for improvement, the initial demonstration has validated our ability to resolve the key oversight issues identified as a program goal.

Compensation and Pension Service Oversight of Contract Medical Examinations Background

Medical examination reports are an important part of VA's disability claims process. They provide VA regional office rating personnel with a means to establish service connection if a medical opinion is needed and evaluate the severity of a Veteran's disabling symptoms for compensation purposes. A standardized protocol with specific worksheets for various types of examinations was developed jointly by the Compensation and Pension (C&P) Service and VHA. Although the majority of these examinations are conducted by VHA, C&P Service has authority to contract with outside medical providers in the examination process. During fiscal year 2008, medical disability examination (MDE) contractors conducted approximately 24 percent of all compensation and pension examinations.

MDE Contractors

C&P Service has contracted with two MDE providers: QTC Medical Services, Inc. (QTC) and MES Solutions, Inc. (MES). The initial authority for use of contract examinations is found in Public Law 104-275, enacted in 1996. The authority is limited to ten VA regional offices and authorizes use of mandatory funds for the examinations. QTC was first awarded the contract in 1998. This authority required a report to Congress on the feasibility and efficacy of contracting for examinations from non-VA sources. VA selected the ten regional offices to reflect a broad range of claims activity, including: (1) offices participating in the Benefits Delivery at Discharge Program (BDD), (2) offices in remote and medically underserved areas where Veterans had to travel long distances for examinations, and (3) offices in areas of high demand for examinations that may require longer waiting periods to get appointments. Two of the ten offices selected are involved with BDD and process QTC pre-discharge examinations for separating service members that are conducted at 40 different military base sites.

Following submission of the VA report in the autumn of 1997, Congress took no further action to modify, expand, or rescind the authority. QTC successfully competed for a re¬bid of the contract in 2003 and this is the contract currently in force. During fiscal year 2008, QTC completed 117,089 examinations.

Public Law 108-183 provided VA with supplemental contracting authority that differed from the existing authority in the following ways: (1) funding for examinations under this authority utilizes discretionary funds, (2) the number of locations at which VA may use contract examiners is not limited, and (3) the authority currently will expire on December 31, 2010. PL 110-389, section 105 extends the authority of PL 108-183 until December 31, 2010. MES has been awarded the contract under this authority and began performing examinations in August 2008. Six VA regional offices order at least some of their examinations from MES. This contractor currently performs approximately 1,550 examinations per month.

VA Oversight

C&P Service oversees both of these contracts. The oversight involves three standards of performance: quality, timeliness, and customer satisfaction. These performance standards are evaluated quarterly. The contract provides for financial incentives and disincentives for superior and below standard performance respectively. The quality performance measurement for both contractors involves a review of examinations to determine how closely they follow the approved examination protocols for each medical disability. In addition to performance evaluations, C&P Service oversight includes an audit of the financial reimbursement process. An independent auditor monitors the billing statements presented by QTC and MES to VA and assures that they are accurate and appropriate for the work performed. Oversight audits are performed twice yearly.

There are three primary performance measures for assessing contractors.

• The QTC quality performance standard requires at least a 92 percent accuracy rate. Quarterly, 384 examination reports are randomly selected from the ten VA regional offices and their BDD sites. Reviews are conducted by the Medical Director of Contract Examinations and C&P Service rating experts for accuracy.

• The timeliness performance standard is 38 days measured from the time the contractor receives the examination request until the final examination report is entered into the electronic system for retrieval.

• The customer satisfaction performance standard is based on a survey questionnaire given to the Veteran as part of the examination. An independent contractor distributes, receives, and analyzes the results. The questionnaire asks for information on the following: medical office wait time; performance of medical administrative and support staff; reasonableness of medical office visit time and place; cleanliness of the medical office; performance and responsiveness of the medical examiner; and the overall satisfaction with the medical office visit. Answers provided by Veterans are converted to an overall percentage rate. A customer satisfaction standard of at least 92 percent is required.

Conclusion

Mr. Chairman, VA prides itself on providing consistent, high quality care to Veterans, but we know there are times and locations where we cannot meet every possible medical need for our Veterans. In these situations, contracting and fee-basis agreements are important complements to VA's national system of health care. We recognize the importance of our responsibilities in the oversight of care purchased outside our facilities or provided by contractors within our facilities, and we continue to develop initiatives intended to improve the oversight of these agreements. We are exploring opportunities across the Department and across the government. Thank you again for the opportunity to testify. My colleagues and I are prepared to answer your questions.