REVIEW OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS CONTRACT HEALTH CARE: PROJECT HERO

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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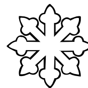

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REVIEW OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS CONTRACT HEALTH CARE: PROJECT HERO

WEDNESDAY, FEBRUARY 3, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Teague, McNerney, Perriello, Brown of South Carolina, and Boozman.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee on Health to order. Mr. Brown will be here shortly. I would also like to ask the first panel to come forward as well. The Subcommittee on Health today will examine whether the VA's Project on Health Care Effectiveness Through Resource Optimization, known as Project HERO, is meeting the goal of delivering efficient, high-quality contract care to our veterans.

Each year, the U.S. Department of Veterans Affairs (VA) spends more than $2 billion to purchase private, non-VA health care for eligible veterans. The VA has the authority to do this when VA facilities are not able to provide the necessary health care or geographic accessibility to our veterans.

There is room for improvement in the way that the VA manages and coordinates contract care. Specifically, there is no consistent process in place to ensure that care is delivered by fully licensed and credentialed non-VA providers. This continuity of care is monitored and is part of a seamless continuum of services that ensures clinical information flows to the VA.

It is under these circumstances that the VA developed the Project HERO pilot program in response to the language in the Conference Report accompanying the VA's 2006 Appropriations Act.

As the VA was in the initial stage of developing and implementing Project HERO, the full Committee held a hearing on this issue in March of 2006. At this full Committee hearing, the VA testified that Project HERO aimed to provide quality cost-effective care, which is complementary to the larger VA health care system.

In this endeavor, the VA also testified that they would sustain ongoing communication with the VSO community.

We have since learned that the VA is implementing Project HERO in Veterans Integrated Services Networks (VISNs) 8, 16, 20, and 23. On October 1, 2007, the VA awarded the Project HERO contract to Humana Veterans Healthcare Services (HVHS) and Delta Dental Federal Services.

We understand that the health care services became available through Humana on January 1, 2008. And that the dental services became available through Delta Dental soon thereafter on January 14, 2008.

With nearly 2 years of rich program data, our hearing today will examine whether the VA has delivered on the promises of Project HERO. For example, was Project HERO implemented properly to meet the pilot program's objectives to provide improved access, quality, and cost-effective care? Was there transparency in the implementation of this program? And was the VSOs community informed and involved in the process? Finally, what has Project HERO achieved and what are the potential next steps moving forward?

To help us answer these questions, I look forward to the testimony of the different panels today. And at this time, I would ask Mr. McNerney if he has an opening statement.

[The prepared statement of Chairman Michaud appears on p. 35.]

Mr. MCNERNEY. Thank you, Mr. Chairman. I'll waive my opening statement.

Mr. MICHAUD. Mr. Perriello.

Mr. PERRIELLO. No.

Mr. MICHAUD. Once again, Mr. Brown should be here shortly. I figured if I read my statement slowly that he would make it. But he will be here shortly.

On our first panel, we have Denise Williams from the American Legion, Adrian Atizado from the Disabled American Veterans (DAV), Tom Zampieri who is from the Blinded Veterans Association (BVA), and Bernard Edelman from the Vietnam Veterans of America (VVA).

We will start with Ms. Williams.

STATEMENTS OF DENISE A. WILLIAMS, ASSISTANT DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; THOMAS ZAMPIERI, PH.D., DIRECTOR OF GOVERNMENT RELATIONS, BLINDED VETERANS ASSOCIATION; AND BERNARD EDELMAN, DEPUTY EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF DENISE A. WILLIAMS

Ms. WILLIAMS. Good morning. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on the Department of Veterans Affairs health care contract program known as Project HERO. These views are

based on quarterly update briefings given to Veterans Service Organizations (VSOs) by VA.

The American Legion is concerned with quality of care, the timeliness of access to care, and patient satisfaction. The stated goals of Project HERO deal with managing the "fee based" health care services.

If I may paraphrase, "In order to streamline the process, reduce cost, and ensure security of records, of contracted health care." In briefings received by VSOs from VA, these goals seem to be in reach.

The American Legion reiterates the priority need is for quality health care in a timely manner to be provided. Currently, Project HERO sets up appointments with "certified" caregivers. It is our opinion that VA should increase its efforts to enforce criteria for the certification of caregivers, do follow-up investigations, and conduct training to assure care given by contracted caregivers meets the quality of care standards received at the VA facility.

This oversight would not only assure quality health care, but it will improve customer satisfaction in the overall process. This is once caregivers are VA "certified", the need for extended review of recommended treatment by VA experts, as is now the case, would not be necessary.

The American Legion recommends that under Project HERO, VA consider mirroring the private sector's approval practices for treatment between doctors and insurance companies; allowing veterans to have timely access to quality health care as opposed to waiting for an extensive VA review of the recommended treatment.

Since patients would only be sent to "VA approved and certified" commercial facilities for treatment, it would be generally accepted that recommended procedures be allowed and conducted. These treatment procedures should be reviewed after patients are treated. If it is found that excessively expensive or unnecessary treatments have been performed, the service provider should be charged back or decertified for repeat infractions.

The American Legion urges VA to expand access to Project HERO to veterans in other VISNs, particularly those VISNs with extensive rural veteran's populations or limited access to VA facilities, such as Alaska and Hawaii.

This is to assure that veterans residing in areas with limited access to VA medical facilities are not subjected to insufficient health care. Knowledge and understanding of existing programs by veterans is critical to success.

The American Legion urges that every measure be taken to assure these advances are communicated and implemented within the rural and higher rural areas to provide all veterans with timely access to quality care, quality health care in the proper settings.

While not originally designed to address the rural health care, initial results from four VISNs in the pilot project indicate that Project HERO could, in fact, be an important component to addressing the health care access issue.

Finally, the American Legion would like to emphasize that this program should not be utilized as a means to control the VA Medical Center's budget by referring veterans to Project HERO resources in order to save on equipment repair or purchases. For ex-

ample, if the emphasis on cost savings becomes too great, we could see a scenario where an administrator would delay repair or purchase of a piece of equipment, justifying it by utilizing Project HERO health care and thereby enhancing budget numbers.

We would like to encourage VA to continue to maintain a health care system which 8 million veterans rely on for their care. It is imperative to note that the Project HERO should not be intended to replace the VA health care system.

Mr. Chairman and Members of the Subcommittee, the American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on this important matter. This concludes my statement.

[The prepared statement of Ms. Williams appears on p. 36.]

Mr. MICHAUD. Thank you very much. Mr. Atizado.

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Chairman Michaud, Ranking Member Brown, Members of the Subcommittee, I would like to thank you for inviting the Disabled American Veterans to testify at this important oversight hearing on VA's Project HERO.

The DAV is an organization of 1.2 million service-disabled veterans and devotes its energies to rebuilding the lives of disabled veterans and their families.

The DAV believes Project HERO is timely considering about 40 percent of veterans receive some of their care from a non-VA health care provider. Also considering the escalating rise in VA spending for purchased care and the manner by which such care is currently managed.

As you had mentioned, Mr. Chairman, VISNs 8, 16, 20, and 23 were selected to ensure that demonstration results are representative of the larger VA population and to facilitate measurement of the proof of concept under Project HERO.

Contracts for this demonstration project have a base year and is now in its 3rd of 4th option years. DAV believes VA has demonstrated, through Project HERO, its ability to deliver on the ideas our organization has expressed previously and still now to improve VA contract care coordination.

I'll name four items in particular: Oversight of clinical care quality provided by the contractors and care is delivered by fully-licensed and credentialed providers and must meet VA-defined quality standards.

Coordination of care is performed by the contractors by communicating directly with the veteran and the prospective provider.

Continuity of care is monitored by the contractors and VA as patients are directed back to the VA health care system for follow-up when appropriate.

Clinical information necessary to provide care under Project HERO is provided by VA to the contractors. And records of care are scanned by contractors and sent to VA for annotation in its Computerized Patient Record System or CPRS.

While this list is certainly a tremendous improvement over VA's Purchase Care Program, it is not complete. And thus, our organization's concerns remain.

As indicated in my written testimony, evaluating Project HERO requires greater detail than is currently being provided to include validated and comparable data.

For example, access to care, we have not been provided data to compare VISN facility versus HERO providers on travel distance or patient satisfaction for convenience of provider location.

In addition, we do not have information on VISN compliance for either VA provided or VA purchased care to compare timeliness to access to care standards under Project HERO. Now these standards include appointment scheduling being done within 5 days, completed appointments within 30 days, or office wait times of less than 20 minutes.

It remains uncertain whether measurements and Project HERO's impact on VA facilities and academic affiliates accurately capture whether or not Project HERO compliments rather than supplants the VA's health care system. And whether partnerships with university affiliates have been sustained.

Further, VA employees in the field have raised concerns to DAV about VA's claims auditing procedure, which may need refinement to minimize risk of overpayment.

Mr. Chairman, the quarterly updates VA has provided to veteran service organizations have indeed been informative. And DAV is working closely with Veterans Health Administration's (VHA's) Chief Business Office to ensure future reports provide more consistent and meaningful data.

Now since this matter first emerged in the fiscal year 2006, Congressional appropriations arena, it has remained a significant concern, as with our colleagues, that Project HERO, as with all other non-VA purchased care programs, does not become a basis to downsize or privatize VA health care. Now to that end, DAV would like to express our appreciation for VA's effort to address these concerns and those of the veteran community.

As DAV continues to work to ensure Project HERO achieves the goals we have advocated, we encourage this Subcommittee to continue its oversight, which would help ensure this demonstration project will provide a model for contract care coordination.

This concludes my statement. And I would be pleased to answer any questions you or the other Members may have.

[The prepared statement of Mr. Atizado appears on p. 37.]

Mr. MICHAUD. Thank you very much, Mr. Atizado.

Dr. Zampieri. I'll just call you Doctor for short.

STATEMENT OF THOMAS ZAMPIERI, PH.D.

Dr. ZAMPIERI. Mr. Chairman you were close.

I appreciate the opportunity to testify here today before you and the other Members of the Subcommittee on Health.

Blinded Veterans Association, along with the other veteran service organizations today that appear here that support the *Independent Budget* (IB) has been concerned about contracted care services within the VA's system for a long time.

And actually, how we ended up here today was I think individuals looked at IB report language and decided that this was an avenue of approach.

Our testimony here basically, you know, we are concerned about the old fee-based system and that VA move to more coordinated, high-quality care with improved access and cost-effective delivery of those services for veterans.

Along with that, any contracted care should essentially ensure full development of bidirectional compatible electronic health care record (EHR) so that VA clinicians and health care providers can access all of the clinical notes or diagnostic services being provided by any outside contracted care.

The IB stressed that participating preferred providers should use a provider pricing program to receive discounted rates for services rendered to veterans with only credentialed, high-quality providers utilized in contracted care. Customized provider networks should complement the capabilities of and the capacity of each VA Medical Center and not replace those as the veterans' first choice of care. The VA health care system has undergone tremendous positive changes in the past decade, bringing it high acclaim for its leadership in quality and for its outstanding utilization of information technology and electronic health care records in advancing health care for our Nation's veterans.

We are concerned about the impact of this on academic affiliations. And again I want to stress on the impact of staffing decisions made at local VA medical centers within the four networks where Project HERO is currently going on. We want to make sure that there is full transparency in regards to the costs in the program and the reporting of the records to the VA in a timely fashion on any outside tests that are done, or consults, or procedures that are done.

The VA's confronted with an extremely complex social medical system challenge today. The American health care system, as everyone in this room knows, has been brought before Congress this past year in regards to recommendations on changing health care access. And all of this is going to have an impact on the VA system. And these are all difficult challenges.

Long-term comorbidities, unique mental health problems, the triad of access, cost, and quality that all impact the decision-making practice and health care environment are all impacting this.

We have some recommendations here. And rather than read through all those, I think I will go to my conclusion and to just say that we, again, appreciate the opportunity to be able to present the testimony here today.

It is sort of interesting in the fact that today we are not sure where exactly health care reform is going to end up, and what specific changes may occur, and how those will impact the VA's system.

And hopefully, Project HERO and other contracted care will be looked at closely in regards to how the VA improves its services and the ability of veterans to access the system.

Thank you again for the invitation to testify today. I would be happy to answer any questions.

[The prepared statement of Dr. Zampieri appears on p. 42.]

Mr. MICHAUD. Thank you very much, Dr. Zampieri.

Mr. Edelman.

STATEMENT OF BERNARD EDELMAN

Mr. EDELMAN. Yes, sir. Good morning, Mr. Chairman, Mr. Brown, other Members of this distinguished Subcommittee. First off, Vietnam Veterans of America wants to thank all of you for the work you have done and continue to do on behalf of America's veterans. It is critical. And we appreciate it. I think I can speak for every veteran in this room.

You are going to be given or have been given a lot of information with a lot of numbers about Project HERO. And we would caution that you do not be bedazzled by the numbers. Yes, there are lots of them.

We believe that it was the intent of Congress to get a handle on, to optimize the money spent for fee-basis care, understanding, of course, that what costs $100 let us say in Boston or in Bangor, Maine, might cost $80 in Dubuque or Duluth.

A commendable purpose from Congress for not an inconsiderable amount of money, as you pointed out, Mr. Chairman, more than $2 billion a year goes to fee-basis care from the Department of Veterans Affairs.

The goal, though, is not to transmogrify the VA health care system. It is to fill in gaps, not to replace wholesale a variety of services in various VISNs. It is to be, to use your words, sir, complementary.

Are the health care services rendered by Humana and by Delta Dental enhancing health care delivery at the Veterans Affairs Medical Centers (VAMCs) and the Community-Based Outpatient Centers (CBOCs) in which this pilot project is ongoing?

Further, while this project was supposed to fill in services when the VA had trouble recruiting key specialists in a reasonable time, are these temporary fixes now becoming permanent? And is the VA, Veterans Health Administration, no longer trying to fill the vacancies on its own staff at relevant VA medical centers? Are they succeeding in filling in the gaps in VA service at a significant cost savings to the VA? We are really not convinced they have, despite the numbers.

During our quarterly briefings with VA officials, we are given thick reports festooned with charts and graphs and numbers. What we are not given is any real evidence that HERO is improving or enhancing care available at the VAMCs and CBOCs.

What seems to have evolved is a parallel health sub-system in these VISNs. This is our concern. What was supposed to supplement or complement VA health care seems to be supplanting basic care and not only in rural and remote areas. This was not, we believe, the intent of Congress.

Through the fiscal largesse of Congress for VA health care operations over the past 3 years, it seems to us that rather than pay a middleman, which is what Humana and Delta Dental are, the VAMCs and the VISNs ought to be able, on their own, to get a handle on dollars for doctors and other clinicians whose fee-basis services are necessary for the provision of timely health care to veterans who either reside inconveniently away from VA facilities or who cannot get appointments in a reasonable amount of time, either with primary care providers or with specialists.

VVA sees no reason why internal units at these VISNs and VA medical centers can't assemble a roster of clinicians and regulate fee-basis care, insuring that such care is available, is of high quality, and can be integrated into the VA's electronic health record system.

Just as important, the entire business model of HERO threatens the underpinning of the VA health care system. VISN and VAMC directors can find it fiscally advantageous in the short term to outsource more and more of their services. This can, and we believe will, eventuate in the shuttering of outpatient clinics as well as, potentially, VA medical centers.

We agree with the statement by then Chairman Steve Buyer who stated on March 29, 2006, "This initiative is not intended to undermine our affiliations, or lead to expanded outsourcing or the replacement of existing VA facilities. It should instead help us learn how to improve some of the contracted care we now provide and the way we provide it."

If Project HERO accomplishes this, then it will have been a worthy experiment. But that is all it ought to be, an experiment, and not an answer.

Thank you.

[The prepared statement of Mr. Edelman appears on p. 45.]

Mr. MICHAUD. Thank you very much. I appreciate all of your testimony this morning. I have one quick question for Mr. Atizado.

You provided some examples of instances where Project HERO does more for our veterans than the existing fee-basis programs, most notably the collection and tracking of certain data. Can you summarize for us the elements of Project HERO you believe have the potential to improve the current fee-based programs if they were to be applied systemwide?

Mr. ATIZADO. Thank you for that question, Mr. Chairman.

One thing I would like to point out at the outset is that Project HERO is a contract-based system, health care—is contract based. Fee based on the other hand is more like fee services, much more passive.

While there are lessons learned and proven concepts that have been gathered out of Project HERO, as I listed in my oral testimony, whether that can be applied to fee basis I think may prove more difficult, simply because it is a different program all together.

Although, the idea that VA can track and manage the care that a veteran receives in the private sector, I think should be the end goal of any non-VA purchase care program that VA manages.

Fee basis is fraught with problems. And to compare Project HERO to fee basis, in my opinion, it sets such a low bar that a comparison with it is going to turn out good regardless.

So I don't know if I was able to answer your question. But it is very hard to do that, sort of to transport what we have learned with Project HERO to fee basis in my opinion.

Mr. MICHAUD. Thank you. This question is for everyone on the panel. As you know, the VA was supposed to involve the VSO community as it was implementing Project HERO.

Do you feel the VA has adequately involved your different organizations as they have moved forward with Project HERO? If not, how could they do so, so that there is more transparency?

I will start with Ms. Williams.

Ms. WILLIAMS. They have been transparent as far as the quarterly updates with the information. I think the only thing that they could perhaps do is be more in depth with the patient satisfaction.

As Adrian stated, you know, we should have some kind of way to find out definitely. We are getting numbers, and we are getting charts. But, you know, we need more in-depth analysis of the care that they are receiving.

Mr. MICHAUD. Mr. Atizado.

Mr. ATIZADO. Mr. Chairman, as my colleague, Mr. Edelman and Denise, had mentioned, these quarterly briefings are most definitely heavy with data.

My only critique is that the information that is provided to us on a quarterly basis is not necessarily presented consistently. There are certain things that they want to present to us. There are certain things that the VSO Committee wants to find out.

And, unfortunately, things such as access to care, travel time, patient satisfaction, as well as contract requirements the information that VA has provided to us we cannot compare across the board.

Whether it is comparing to HVHS, Delta Dental, the VA facilities by VISN, or by non-VA provider, it just—we can't do—I can't—personally can't do a spreadsheet to show the scoring for each one of those. It is very hard to do a very good comparison under Project HERO.

But I must say the Chief Business Office has been working extremely hard to do that. Even though at times for the information that we ask they don't have the structure or the means to do it, they still try and provide surrogate information.

Mr. MICHAUD. Doctor.

Dr. ZAMPIERI. Yes. I just concur with my colleagues here on that. The briefings are very good. There is a tremendous amount of data.

You know, the 800-pound gorilla in this room right now, that it would be interesting to see if anybody dares say this is, you know, you look at the total costs of VA's contracted care and fee basis in the last 3 years.

I mean you talk about health care costs in this country and escalating and inflation rates. And where are we going to be in 2 years? What is the total cost going to be for all this?

See nobody wants to, oh, well, you know, we will go into microscopic details of the numbers of veterans in each medical center that has been referred or whatever. You know, the reports are huge. Where are we going? Are we going to spend $5 billion in 2 years?

You know, that is what is going to impact the system. That is what the medical center directors who are bold enough to talk in confidentiality about this are afraid of.

You know, I mentioned in my testimony, and I don't want to go too long here, but, you know, health care in this country and everything else associated with it, you know, if we start to cut Medicare plans, what happens in that impact with, you know, veterans? Is it going to force more veterans into the system and more enrollment, and, therefore, you know, more utilization, more costs?

I am not sure where we are headed. And I don't think—well, we will leave it to others to see where we are headed. Thank you.

Mr. MICHAUD. Thank you.

Mr. EDELMAN. Mr. Chairman, let me say that initially the VA was not transparent at all. HERO was a done deal, period, end of story. It was only when the VSOs basically demanded that we get quarterly updates, quarterly briefings, that we finally got them.

This wasn't any largesse on the part of the VA. Now we do get quarterly briefings in which we listen to the numbers. We do criticize. We do ask questions. And I believe that many of our questions do get responses, replies. And they are trying to understand our concerns, because I think they realize we are all in this together.

And they also are under the glare of the floodlights, so to speak, in Congress.

Mr. MICHAUD. Thank you.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much for your insight.

Let me just ask a couple of general questions. And this will be to all the members of the panel.

You expressed concern that under this demonstration project VA will pay significantly, expand contract care without safeguards of VA high-quality standards. What safeguards are missing? And what recommendations do you have to ensure that the necessary safeguards are in place?

I guess number one, let me preface this by saying, do you think this is a good idea or not a good idea?

Ms. WILLIAMS. We believe Project HERO is an excellent project program, especially for the veterans in the rural areas.

As stated in my testimony, we see where the veterans in rural areas are little utilized in this program. And, you know, with the current conflict going on, a lot of veterans they tend to move away from the urban areas into the rural areas.

And so this has really enhanced the care that they are receiving. So I would say that it is an excellent program. And the concern is that Project HERO will not remain permanent and it won't eliminate the veterans health care system for veterans. It is a temporary fix and that the VA should be able to meet the desires for the veterans to receive their care at a facility. So I do believe it is an excellent program.

Mr. BROWN OF SOUTH CAROLINA. I know I had the opportunity to go up to the Chairman's district in Maine about 5 or 6 years ago and had some town hall meetings with the veterans there.

I don't know whether you have been to Maine or not. But it is a pretty big expansive territory. Is it half as big as Texas? It is the next largest State to Texas?

Mr. MICHAUD. Correct.

Mr. BROWN OF SOUTH CAROLINA. But not including, you know, Alaska. But they have like 1.1 million?

Mr. MICHAUD. 1.3.

Mr. BROWN OF SOUTH CAROLINA. 1.3, oh it is growing some. And so that is a major problem to try to, you know, address the health care for those veterans that might be 300 miles away from a facility? And so this was just kind of an idea to try to bridge that.

But I certainly, you know, appreciate everybody's input. I have a couple of other questions. But if anybody else would like to fill in. Do you think the quality of care is being sacrificed doing this?

Mr. ATIZADO. Ranking Member Brown, that is the million dollar question, one of I should say. There hasn't been any, as far as I know, I don't think VA has actually looked at comparing the quality of care. I mean, there are a number of ways to measure that and to compare it. But I don't think it has been done.

I think the idea that resting on credentialed providers, licensed providers, and having set up a patient safety process whereby is a patient has a complaint of has an adverse event, that the current Project HERO has something to address that I think is one thing. And to actually compare to actual VA care is another.

I certainly don't have the information nor can I tell you here today that, in fact, it is as good or better than VA care.

Mr. BROWN OF SOUTH CAROLINA. Do you think the 2 billion is too much? I know that somebody expressed maybe it might grow even more. But do you think the money that is being spent in this program is diminishing the care in the conventional VA health care delivery? Do you think they are competing against each other or supplementing each other?

Mr. ATIZADO. That is a very complex question, Ranking Member Brown. The problem with—in my opinion, the problem with trying to ascertain whether or not a non-purchase care program that VA has is supplanting or complimenting the overall VA health care system.

It really depends on how you want to measure that. If you talk about, as my colleague, Mr. Edelman, here had mentioned, that there are staffing vacancies that haven't been filled. If you want to use volume of services, if you want to use cost that is being expended for these services, there are a number of ways to answer that.

But I really think it is a dangerous position. It is a hard position to be in to make that call, because that really depends on the facility and the VISN and their responsibilities to protect the VA.

When we start getting down that road, if it gets very complicated very quickly, because we are, in fact, making a judgment call on how well the facility and the financial officer of that facility or the VISN is doing its job.

Mr. BROWN OF SOUTH CAROLINA. Mr. Chairman, I notice my time has expired.

Mr. MICHAUD. Thank you.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. You know, it is gratifying after all the complaints we hear from various parts of the country about the VA. How the real experts are saying our veterans want to stay in the VA system. The VA hospital really provides the best care.

So it is really gratifying to hear that from you. I appreciate those sorts of comments.

And I am hearing that overall Project HERO is satisfactory. Veterans are getting reasonable treatment, reasonable expectation. One thing I am concerned about is outreach. How effective is the message out there to veterans that aren't within some enactment

area? How effective is the message that they can take part or participate in this sort of a program?

Whoever wants to answer that question. Mr. Edelman, do you have a comment?

Mr. EDELMAN. I am not sure I have an answer to that, sir. We don't know what their outreach precisely is in any of the four VISNs. So I really find it difficult to answer that question.

But if I might, I just would like to reply to something that Mr. Brown said. HERO is an experiment. It is a pilot project. But we still believe that the safeguards for health care for veterans is better provided within the VA health care system, not out of it.

Yes, there is a need for out-of-system services. But the VA itself ought to be able to recruit these health care providers in rural and remote areas as well as in inner cities and get the word out to the veterans residing in these places.

Mr. MCNERNEY. Thank you.

Ms. Williams, I think I understood you to say that there were unnecessary delays in proving cases for Project HERO. And that it is better to go ahead and make those assessments quickly and then later decide if that was a problem or not. Is that what I understood you to be getting at there?

Ms. WILLIAMS. Yes, sir. That was my recommendation. Instead of having the veteran wait around to receive the care, perhaps they should mirror the practices of the private sector. Allow the veteran to receive the care and then later on do the reimbursement and oversight.

And if the physician in fact over provided care to the veteran, then they can go back and take actions later on instead of having them sit around, because as we know, the wait time was one of the main concerns in the VA system. And if Project HERO is supposed to be a fix for that, we feel like we should try to eliminate that.

Mr. MCNERNEY. Thank you.

One of the themes that I hear from this panel, and I am sure the other panels as well, is that we don't want Project HERO and the other fee-for-service type programs to replace VA services.

And Mr. Edelman just reinforced that with his statement. And I think that that is excellent feedback from you all. And I am sure that we will try to do our best to make sure that that doesn't happen.

But there are cases, obviously, where it is not practical to put up a VA facility. And I think everybody understands it. And also it has been difficult to recruit qualified people to be in the VA.

So there is certainly a need for this. And I am happy to hear that the program is moving along okay.

Dr. Zampieri, you did mention that you had some concern about this elephant of the cost increase in the next few years. And I think that is an excellent point. Is your concern that the increase in health care costs in general is going to drive veterans that are not in the system now to come into the system, driving up the cost to the VA? Was that sort of what you were getting at there?

Dr. ZAMPIERI. I think it is a combination of different things that are impacting the system.

You know, it is interesting most of the health care dollars are spent for procedure for encounter driven types of services. In other words, the more patients that come in for——

Mr. MCNERNEY. Right.

Dr. ZAMPIERI [continuing]. X-rays, or lab, or for whatever, the more, you know, collections occur or, are paid for that way.

And then, you know, whereas, if you look at a different way of maybe managing this is comparative and concurrent performance data, which is not a usual part of health care culture. Reimbursement that instead of it being procedure or encounter driven is more geared towards outcome and bundle the payment, you know, which is going on some——

Mr. MCNERNEY. So are you referring to services within the VA, or HERO type services, or services in the health care system in general?

Dr. ZAMPIERI. Yes, outside of the VA. Yes, outside of the system, and how it is currently done, and how that impacts VA's fee basis and contracting of services.

Are you just going to keep—let me make it more clear. Are you just going to keep paying for individual encounters and individual procedures, or are you going to try to really, if you want to do a pilot study, you create something where you say, okay, I have, you know, X number of patients and they have congestive heart failure, diabetes or whatever. And we are going to give you a performance kind of payment for, you know, the care for that person for a year.

Mr. MCNERNEY. Right.

Dr. ZAMPIERI. Or, you know, they do that like I said with surgical procedures now.

Mr. MCNERNEY. Well, I have sort of outrun my time here, so I need to ask you to wrap it up. And then I am going to yield back.

Mr. MICHAUD. You finished?

Dr. ZAMPIERI. Yes.

Mr. MICHAUD. Okay. Mr. Teague.

Mr. TEAGUE. No, thank you. I will pass.

Mr. MICHAUD. Well thank you very much.

Once again, I want to thank the members of this panel for their testimony this morning. We look forward to working with you as we move forward to try to get our questions relating to Project HERO answered.

I am quite confident there will be some more written questions coming your way. So please get the replies in as soon as you can.

So once again, thank you very much.

Mr. EDELMAN. Thank you.

Mr. MICHAUD. I would ask the second panel to come on up.

We have Mr. Panangala who is from the Congressional Research Service (CRS) and Ms. Finn from the Inspector General's Office (VA OIG). Ms. Finn is accompanied by Mr. Abe.

I want to thank the second panel for coming forward. I look forward to your testimony. We will start with Mr. Panangala.

STATEMENTS OF SIDATH VIRANGA PANANGALA, SPECIALIST IN VETERANS POLICY, CONGRESSIONAL RESEARCH SERVICE, LIBRARY OF CONGRESS; AND BELINDA J. FINN, ASSISTANT INSPECTOR GENERAL FOR AUDITS AND EVALUATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GARY ABE, DIRECTOR, SEATTLE OFFICE OF AUDITS AND EVALUATION, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF SIDATH VIRANGA PANANGALA

Mr. PANANGALA. Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee on Health, my name is Sidath Panangala. I am from the Congressional Research Service.

I am honored to appear before the Subcommittee today. As requested by the Committee, my testimony will highlight observations on the implementation of Project HERO. My testimony is based on the CRS report that has been submitted for the record.

Let me just lay out some of the policy discussion here and then jump into some of the questions that we were trying to answer.

Policymakers and other stakeholders hold a variety of views regarding the appropriate role of the private sector in meeting the health care needs of eligible veterans. Some believe that the best course for veterans is to provide all their needed care in VA facilities under the direct jurisdiction of the VA.

On the other hand, some see the use of the private sector as important in assuring the veterans' access to a comprehensive slate of services, in particular, specialty services that are needed infrequently or in addressing geographic or other access barriers.

Those who believe that all needed care should be provided by the VA and VA-owned facilities are concerned that the private sector options for providing care to veterans will lead to a dilution of quality of the health care system and could fail to leverage the key strengths of the VA's health care network.

Still others hold the view that over the long term, having private sector options could improve the quality of services within the VHA network through competition.

Reaching the correct balance between providing care through the VA's network and through non-VA providers is an issue for policymakers, as well as for the VHA and other stakeholders.

There are at least two policy questions about Project HERO that may be of interest to Congress. Has Project HERO enhanced the existing fee basis care program? Are there findings from Project HERO that could be applied to standardize the fee basis care program throughout the VA health care system?

Now let me attempt to answer these questions. Has Project HERO enhanced fee basis care? During our visits to three of the four demonstration sites, we heard mixed reviews about the pilot. Some categorized it as a "tool in a toolbox," meaning that Project HERO was one of many options the VA medical facilities could use to provide care outside the VA health care system.

Some officials categorized Project HERO as a "concierge service" where Humana Health Care guides the veteran in scheduling the

appointments, ensures that the clinical information is provided back from the network provider to the VA, maintains a credentialed network of providers, and then provides claims payment to the health care providers.

Are there lessons to be learned from the pilot? Establishing a robust network of providers takes time, even when dealing with a health care system that has already been established like Humana.

Most VISNs stated that early on in the pilot Humana had a fair to moderate success in building its network of providers within the VISN. And that the short implementation period between the time the contract was first awarded and then became operational in January 2008 was inadequate to establish a robust network.

Second, establishing services and pricing and keeping them up-to-date is a challenge. Some VISNs stated that clinical care services included in the contract were based on prior needs that did not meet the current needs of the network. Some VISNs maintained that some contract pricing is higher than what VA would have paid under the regular fee basis care and some were cost-prohibitive when the value-added fees were included.

Education is needed for a successful functioning of the program. And most of the VISNs we spoke to mentioned that educating providers about the program was a challenge.

And finally, the project has yielded information that could be applied to the existing fee basis care program.

First, without electronic sharing of medical records between the VA health care system and non-VA providers, there are delays in the transfer of clinical information. In some instances this delay may result in a VA provider not being alerted to the need for immediate follow-up care required on a diagnosis or a laboratory result. And this applies to both Project HERO and fee basis care.

Second, VHA's regular fee basis care program could adopt certain quality metrics that are currently used under Project HERO, such as how far the veteran travels to receive his or her care as well as how long the veteran waits once he or she arrives for an appointment.

Last, VA could develop a provider network within each VISN that the veteran could be referred to so that the veteran receives the care from a provider who has been credentialed similarly to a VA provider.

However, prior to implementing this pilot demonstration throughout the VA, it may be useful to conduct an independent evaluation to conclusively measure if Project HERO has been a worthwhile effort.

This concludes my statement. I will be happy to answer any questions the Committee may have.

[The prepared statement of Mr. Panangala appears on p. 46.]

Mr. MICHAUD. Thank you.

Ms. Finn.

STATEMENT OF BELINDA J. FINN

Ms. FINN. Thank you. Chairman Michaud, Mr. Brown, and Members of the Subcommittee, thank you for the opportunity to discuss our findings related to the Veterans Health Administration's purchases of health care services for non-VA providers.

I am accompanied today by Mr. Gary Abe who is the Director of our Seattle Audits and Evaluations Office.

In fiscal year 2009, VHA's medical care budget totaled about $44 billion. We estimate that VHA spent about $5.3 billion, that is 12 percent, to purchase health care services from non-VA entities. They used various mechanisms, including sharing agreements, Federal Supply Schedule contracts, the Non-VA Fee Care Program, Project HERO, and the Foreign Medical Program.

According to the VHA managers, the authority to purchase services from non-VA sources helps to improve veterans' access to needed health care services.

Our audits have found that VHA has not established effective policies and procedures to oversee and monitor the services provided by non-VA providers.

As a result, they cannot ensure that the services are necessary, timely, high quality, and appropriately billed and paid for.

During our audit of non-competitive clinical sharing agreements, we found that performance monitoring for surgical and anesthesiology services provided by contracted physicians at the VA medical centers needed strengthening.

For agreements based on providing a specified number of medical professionals, the contracting officers technical representatives did not monitor the actual amount of time worked or whether the hours worked met the requirements.

For procedure-based agreements, the oversight personnel did not always ensure that VHA actually received or needed the services and that contractors correctly calculated Medicare-based charges.

We projected that strengthening controls over the performance monitoring would save VHA about $9.5 million annually or $47.4 million over 5 years.

Our 2009 audit of the non-VA outpatient fee-care program found that VA had not established adequate management controls and oversight procedures to ensure that it accurately documented, authorized, and paid for outpatient fee services.

In fact, the medical centers improperly paid 37 percent of outpatient fee claims by making duplicate payments and paying incorrect rates. As a result, we estimated that in fiscal year 2008, the medical centers overpaid $225 million and underpaid $52 million to fee providers.

When we look at the impact over 5 years, VHA would overpay $1.13 billion and underpay $260 million for a net overpayment of almost $865 million.

In addition, for 80 percent of outpatient fee claims we reviewed, the medical centers did not adequately document the justification for using fee care or properly preauthorize the services. This increases the risk of additional improper payments.

While purchasing health care services from non-VA providers affords VHA flexibility in terms of expanded access to care and services, it also poses a significant financial risk when adequate controls are not in place.

With non-VA health care costs expected to increase, VHA needs to strengthen performance monitoring over the clinical sharing agreements and improve controls over claims processing and the authorization of fee services.

Without adequate control, VHA lacks reasonable assurance that it is receiving the services it pays for, that the services are needed, or that the prices paid are correct.

In both of our audits we recommended internal control improvements to increase accountability for purchased health care activities.

Mr. Chairman, thank you for the opportunity to testify today. Mr. Abe and I would both be pleased to answer any questions that you or the other Members of the Subcommittee may have.

[The prepared statement of Ms. Finn appears on p. 62.]

Mr. MICHAUD. Thank you very much.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Ms. Finn, could you tell me what you think the major reason was for the underpayment/overpayment of those fees?

Ms. FINN. Yes. Mr. Abe is going to answer that.

Mr. ABE. Basically, our outpatient fee audit identified two major issues that contributed to the improper fee care payments.

The first one is the VHA had not identified core competencies or established mandatory training for the fee clerks. During our interviews with the fee staff, fee staff expressed frustration that they did not have the necessary training to do their jobs. Thus did not have a thorough understanding on how and when to apply the various fee payment methodologies.

For example, fee staff incorrectly paid professional charges. When paying of fee services, medical centers may incur two types of charges, professional charges and facility charges. Professional charges are the fees paid to clinicians for services provided.

Professional charges are paid using a payment hierarchy. The hierarchy requires that the medical centers reimburse providers at the lowest rate between the Medicare physician fee schedule and the VA fee schedule.

Mr. BROWN OF SOUTH CAROLINA. So they establish the reimbursement rate based on those factors?

Mr. ABE. Right, based upon the hierarchy.

Mr. BROWN OF SOUTH CAROLINA. Right. And will the supporting service provider agree to those terms?

Mr. ABE. Yes. There could also be a contract rate if VA established a contract with a provider or a hospital. This contract rate for fee services supersedes the scheduled rates that I mentioned before, even if it is higher. So you have this payment hierarchy.

What our audit found is that VHA did not have a specific training module that provides the in-depth training on the specific payment methodologies I discussed.

Additionally, what we found is that only 53 percent of the fee staff at the medical centers that we visited had attended any basic fee training.

The second issue is VHA's lack of regulatory authority to support payment of outpatient facility charges. Facility charges include space, supplies, ancillary services, and other overhead.

The current Code of Federal Regulation does not authorize VA to use Medicare payment methodologies to pay facility costs. Because VHA does not have the regulatory authority to support payment of

these outpatient facility charges, we found that clear guidance on how to pay for the facility charges to be lacking.

Consequently, VHA has no assurance that the amounts—medical centers pay for facility charges are consistent, reasonable, or proper.

Mr. BROWN OF SOUTH CAROLINA. Let me interrupt you just a minute again. Do you think it might be better than if the VA contracted a third-party collection?

Ms. FINN. That certainly is an option that they could use. Having a third party would give you a professional staff to do this all the time. Although the VA staff does do it all the time.

Mr. BROWN OF SOUTH CAROLINA. But are they in each VISN? Are they——

Ms. FINN. Yes, sir.

Mr. BROWN OF SOUTH CAROLINA [continuing]. In some kind of central?

Ms. FINN. There are a few centralized billing centers at some of the VISNs. But for the most part, the medical centers all handle the bills from the fee providers at each medical center.

Mr. BROWN OF SOUTH CAROLINA. Like in my case in Charleston, you know, the local VA hospital is the—they collect the bills and disperse the costs, the payments, I guess?

Ms. FINN. Yes.

Mr. BROWN OF SOUTH CAROLINA. Is that right?

Ms. FINN. That is correct.

Mr. BROWN OF SOUTH CAROLINA. Wow, I can understand then how that would be, you know, tough to control.

Ms. FINN. It makes it tougher. Yes, much more difficult.

Mr. ABE. It makes it tougher for the facilities as well as for the VA.

Mr. BROWN OF SOUTH CAROLINA. Right. But it looked like to me they would have some kind of—did you all look into some kind of a central for the group?

Ms. FINN. Yes, we did. There are some centralized payment facilities. And we did visit them I believe. But we didn't find any particularly different results.

Mr. BROWN OF SOUTH CAROLINA. Really, 30 something percent?

Ms. FINN. That is an overall rate.

Mr. BROWN OF SOUTH CAROLINA. With the collection groups, too?

Mr. ABE. Pardon?

Mr. BROWN OF SOUTH CAROLINA. If you contract a third-party collection group, the error rate was no different?

Mr. ABE. Oh, I think we misunderstood what you said. Are you asking whether or not we went to a third-party collection group?

Ms. FINN. There are none.

Mr. ABE. No, we did not.

Mr. BROWN OF SOUTH CAROLINA. Okay. Are you all looking into maybe doing that?

Ms. FINN. I believe VHA is evaluating the possibility of centralizing more of their payment process. I don't know that they are considering contracting.

Mr. BROWN OF SOUTH CAROLINA. I know your nursing homes and these other, you know, facilities are included as $5 or $7 billion. Their way of collecting is the same as the HERO's program?

Ms. FINN. I believe the nursing homes bill to the medical centers, also. Sorry, that is correct.

Mr. BROWN OF SOUTH CAROLINA. Okay, thank you.

Mr. MICHAUD. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Ms. Finn, interesting testimony for sure. You use some strong language I think, insufficient oversight, inadequate management. It is sort of subjective judgment.

How do you think this compares as a whole to what you would find in a Medicare investigation or Medicare? Is it going to be—I know it is a smaller set of Federal programs. But, in general, is it comparable in terms of what you are seeing there, or is it worse, or what would be your feeling on that?

Ms. FINN. I don't have any data on what type of payment error rate they have in the Medicare program. I would suspect that some of the issues we found in terms of duplicate payments in that both a medical facility like a hospital would bill for medical services and then the doctor would bill separately. I think we would have the same kind of issues even in a Medicare billing or any kind of insurance programs.

The problem is the ability to take those bills and handle them accurately on the other end. In VA it is a very manual process. For our auditors, when they were comparing bills, they had to manually look through transactions to determine that the payment for that physician services had already been paid as part of a medical facility bill or separately.

Mr. MCNERNEY. You know, my understanding is that actual human eyes that reduces the fraud, you know, the opportunity for fraud is that born out here in any way?

Ms. FINN. Mr. Abe will answer.

Mr. ABE. One of the problems with comparing Medicare and the VA system is that the VA system is very—their automation systems are very old.

And when you talk about Medicare or any other third-party billing or paying claims processing centers, their automation is much more sophisticated, such as artificial intelligence. They have software edits that in itself will identify duplicate payments for example.

Under the VA system, what happens in order to identify a duplicate payment is that the fee clerk has to manually look through this whole payment history.

Mr. MCNERNEY. Right.

Mr. ABE. And it is very, very difficult, and it is very, very time consuming.

Mr. MCNERNEY. So it takes more time.

Mr. ABE. Oh, very much so.

Mr. MCNERNEY. But it may be more able to capture misuse of funds.

Mr. ABE. It is not that accurate.

Mr. MCNERNEY. Okay.

Mr. ABE. I mean, it is very——

Mr. MCNERNEY. Ms. Finn, again, you mentioned in your testimony growth of a 4-year period—over a 4-year period from 2005 to 2008 from $740 million to $1.6 billion.

Do you have any idea what sort of causes of that explosive growth are for outpatient fees?

Ms. FINN. I would be speculating if I were to give you an answer. I believe it would probably be due to the increase in claims in the veteran population and the need for more specialized services.

I will note one of the things that we were kind of looking for and did not find was for VHA to be using the information on what it was paying out for fee-based services. We would hope that they would use that information to drive improvements in their medical centers and make decisions on where to provide the care, you know, and in various specialty areas. And we did not see that anywhere.

Mr. MCNERNEY. Okay. Let me see here. Mr. Panangala, could you shed some light on what the criteria was that distinguished what cases were sent to HERO and what cases were handled by the fee-based program?

Mr. PANANGALA. Yes. Thank you for that question.

Generally the way the fee basis care works is that when you are presented with a situation that because of some reason you can't provide that care, then the clinician makes a choice whether the consult should be sent outside.

The way the Project HERO decision is then made is first they look at can it be provided within network, within our own facilities. Do we have an affiliate that is already having a contract with us to do that? In cases we cannot do that, then we will send it to the Project HERO network, which is already contracted out.

So I think that is what we heard in some of the VISNs we went to and when we had briefings with them. Now some had mentioned that they are trying to have a penetration rate of about 15 percent so that they can send some of them outside the Project HERO.

But the decision generally relies on can we do it inside first. If not, can we send it out.

Mr. MCNERNEY. Can I ask one more question, Mr. Chairman?

You mentioned that the clinician looks at the case first. So what you are saying is that a qualified medical person is looking at these cases before it decides to go out to the VA in the first place; is that correct?

Mr. PANANGALA. Well, the qualified physician says I need to perform this test, or I need to perform this procedure. Can the VA provide it within its network, within its facility.

Mr. MCNERNEY. So is that——

Mr. PANANGALA. So that when I say I need this procedure performed——

Mr. MCNERNEY. Right.

Mr. PANANGALA [continuing]. That goes to a central fee basis office to make that decision, yes, this needs to go outside, because we don't have it in house, or we don't have it with a group already under contract with us, so let us go to Project HERO.

Mr. MCNERNEY. Okay. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. Panangala, can you share your thoughts on the cost effectiveness of Project HERO compared to the regular fee basis care program?

Mr. PANANGALA. Let me try to attempt to answer that question. Thank you for that.

The VA briefed us about a couple of months back on looking at trying to cost compare within, let us say, the certain number of Current Procedural Terminology (CPT) procedures, of course, they use with what they pay Project HERO.

Now the way VA fee basis works is that once we give an authorization to a veteran, the veteran then goes out and finds a physician and gets the service. And then the physician bills the VA. And then there is sort of a Medicare rate that they use.

In the Project HERO, the way it works is that you send it to a network that has already been contracted with Humana. So Humana has already negotiated the rate with that physician of what we are going to pay for that service.

So at the end of the day, we are sending those claims to the VA. And then the VA pays it back to Humana, saying here is the contract.

So based on what VA has shown us or has at least briefed us, they say that is a cost savings when the valued added fees are added in of about $3 million or so in savings. So, I mean, the VA would be better able to answer that question. But that is what they have told us. So with the cost fee, because that is a value added fee added onto these considered services that they are providing.

Mr. MICHAUD. Thank you. This question is actually for both of you.

Project HERO is located in four VISNs. But when you look at the four VISNs, they have a fee-based care program as well. So is Project HERO really a pilot project? If we are looking to compare, should we, for the remaining time for this project, mandate that they all have to go through Project HERO versus a fee basis model?

Ms. FINN. My thought would be that you need to look at the volume of transactions that are coming through Project HERO as opposed to regular fee-based care.

I don't know that I would recommend that you totally go to Project HERO in a VISN. I think you might get a better view across a VISN by having both Project HERO and regular fee basis care. But I do think you have to have enough basis of both to make a comparison.

Mr. PANANGALA. Again, the pilot project—the VA cannot or the pilot project as it is, HERO, cannot take on all the services. I think that there is a need for the VA to continue to provide those services. There are official agreements already in place. There are contracts already in place. You cannot say, well, we are now going to send the universities—we are not going to honor those agreements that have already been put into place.

So it won't be practical to completely eliminate the VA fee basis program at the same time.

I think the bottom line here is that we have learned certain things that could be applied to improve the fee basis program. There are quality metrics, there is where the claims are processed, the way the decisions are made.

A lot of things that the VA never learned before, have come out of this demonstration. And I think there is an opportunity to apply some of that to standardize under the fee basis care program, be-

cause it is such a diverse program. It is very local. It varies from VISN to VISN, from medical facility to medical facility.

And learning those lessons from Project HERO, and, again, it is still in the third year. We still don't know a lot of information. It has varied over a period of time in the contract. So as we move forward, I think there is the potential to learn from the contract and then apply to the fee basis care program.

Just to add another thing. I mean, the VA's also working with Kaiser and other folks to have an integrated medical record system. And how that is going to play into this type of network providers will be an interesting question to look at down the road.

Mr. MICHAUD. Thank you. Once again, I want to thank the three of you for your testimony today and I look forward to working with you as we move forward to further examine whether or not Project HERO is a good program, and what we can learn from it.

So once again, thank you.

I would ask the third panel to come up. Tim McClain is President and CEO of Humana Veterans Healthcare Services, Inc., and Patrick Henry is the Senior Vice President for Federal Government Programs for Delta Dental of California.

We will start off with Mr. McClain.

STATEMENTS OF TIM S. MCCLAIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HUMANA VETERANS HEALTHCARE SERVICES, INC.; AND P.T. HENRY, SENIOR VICE PRESIDENT, FEDERAL GOVERNMENT PROGRAMS, DELTA DENTAL OF CALIFORNIA

STATEMENT OF TIM S. MCCLAIN

Mr. MCCLAIN. Mr. Chairman, thank you very much. Chairman Michaud, Ranking Member Brown, and distinguished Members of the Committee, I am Tim McClain. I am the President and CEO of Humana Veterans Healthcare Services, the contract partner with VA in Project HERO. I am accompanied today by my Chief Operating Officer, Mr. Brad Jones.

On behalf of the dedicated employees of Humana Veterans Healthcare Services, we appreciate the opportunity to discuss this very important demonstration project.

Mr. Chairman, I do ask that my written statement be made a part of the record.

Mr. MICHAUD. Without objection, so ordered.

Mr. MCCLAIN. And also Ranking Member Brown, from all of the employees of Humana Veterans and from all of the veterans nationwide, we would like to thank you for everything that you have done on this Committee. I know that you have made the announcement that you will not be seeking another term. But I wanted to convey from this side of the table our thanks for everything you have done for veterans nationwide.

As this Committee is aware, the veteran-friendly concept for Project HERO was inspired by this Committee. And it was to develop a pilot project in partnership with a commercial company to focus on improved access to care and quality outcomes for veterans referred to community providers for specialty health care or other services.

Through collaborative efforts and a very close partnership with Humana Veterans and VA, we concentrated on three areas that became hallmarks for this program.

Quality health care services, as I have outlined on page 7 of my statement, timely access to care, and cost effective care.

Our collaboration with VA has resulted in what we describe as the HERO model. The model is described more fully in my written statement beginning on page 3, but it is specifically designed to enhance the veteran's overall health care experience and to ensure that quality health care is delivered to the veteran through a community provider.

As you heard from the Inspector General's testimony and from the last panel, they make several recommendations for improvements in VA's administration of fee-based care. I just want to note that the report that they published, that the OIG published on August 3rd, 2009, and the testimony today, did not refer to Project HERO. That was to the regular fee-based program within VA.

In particular, Project HERO currently addresses many of the issues that were raised in the Inspector General's report regarding quality, timely access, clinical return, and especially the improper payments issue that was discussed by the previous panel.

And we believe that Project HERO actually could be a part of the solution for many of these problems in the fee-based office.

Mr. Chairman, we believe the HERO model should be part of the solution for several other pressing initiatives within VA. The HERO model should be standard procedure, first of all, we believe, in all VA fee offices.

The model already has been shown effectively—its effectiveness when deployed in rural and highly rural areas as defined by VA and could be effectively employed to address women's health care issues in many of the geographic areas.

I would like to give an example. We did an analysis of all the referrals we have received in VISN 20, which is a fairly rural area. And of those referrals, 68 percent of the referrals that we have handled under this contract have been for rural and highly rural veterans as defined by the VA's Office of Rural Health Care initiatives.

I also believe that this HERO model can be effectively employed to handle women's health care issues, women veterans health care issues. And many of the issues that are regarding rural health care such as, Mr. Chairman, I know Maine is a very, very rural area as Ranking Member Brown had mentioned. And I believe that the HERO model could really be of assistance in those types of areas.

Mr. Chairman, thank you again for the opportunity to discuss Project HERO and the important contributions it is making to quality veterans health care. And I would be glad to answer any questions from the Committee.

[The prepared statement of Mr. McClain appears on p. 65.]

Mr. MICHAUD. Thank you.

Mr. Henry.

STATEMENT OF P.T. HENRY

Mr. HENRY. Mr. Chairman, Ranking Member Brown, Members of the Subcommittee. As the Chairman indicated, I am P.T. Henry,

and I am the Senior Vice President for Federal Government Programs, Delta Dental of California.

And I would like to thank you for inviting me to join you this morning to talk about our partnership with the Department of Veterans Affairs in the execution of the demonstration project we refer to as Project HERO.

Delta Dental is the Nation's oldest and largest provider of dental services. Through our 39 independent member plans, we provide dental insurance coverage to over 54 million people in all 50 States, the Commonwealth of Puerto Rico, the territories, and other overseas locations.

Approximately four out of every five dentists in the Nation are affiliated with Delta Dental. And our network of approximately 140,000 highly qualified dentists is second to none. Of those, approximately 19,000 are located in the four Project HERO VISNs.

We at Delta began our journey with the VA when it was then the Veterans Administration in the late 70s when we administered the VA Outpatient Dental Care Program in California.

Over the years, our involvement with the Department has ebbed and flowed. But what has not changed, however, is our total commitment to the tremendous men and women who serve our Nation in uniform.

Today, it is both a privilege and an honor for us to administer this program in collaboration with the Veterans Health Administration and the four participating VISNs.

We fully understand and are committed to the goals of Project HERO as articulated in the underlying statute, the implementing contract, and the related documents.

At Delta, we see our role not as a substitute for VA care but rather as an extension of that care when, for whatever reason, required care cannot be provided at the VA's dental clinics.

By making our network of providers available, we complement VHA's in-house capability with high-quality, credentialed providers with whom we have negotiated discounted rates. Basically, we believe Project HERO will, in the long run, lay the foundation that will allow the VHA to provide necessary care to more veterans for less money than is currently paid for fee care.

We are working in close collaboration with our partners in the dental clinics, in the VISNs, and the VHA to improve the exchange of clinical information between our network providers and the various elements of the VHA.

While fostering high-quality care and patient safety, we improve veteran satisfaction and can provide avenues to control costs while eliminating waiting lists based on commercial practices.

We see this as being in contrast to the traditional fee care in which the VA has little influence over the quality of care yet pays billed charges for all the work that is done.

During the period from January 2008 through December 2009, we received 20,898 viable authorizations, which resulted in our making 20,753 appointments for care. Of those, 18,772 have been seen by a dentist and we have received a claim for the dental services rendered.

Once treatment is authorized, our veterans are in the dentist chair on average in 18 days. And during calendar year 2009, over

99 percent were seen in less than 30 days from the day we first received the authorization.

We see this as a clear indication that the program is meeting the established objectives. We are proud of this track record and expect it to improve as we work through the remaining years of the demonstration.

We believe that the key to this success has been the partnership forged between Delta Dental and the VHA to ensure that this demonstration program provides a solid foundation for future decisions about veteran's dental care.

During the 25 months since contract award, we have worked to better understand the culture, the attitudes, and the expectations of our partners, while exposing them to the benefits that private sector dental plans can provide.

There have been, and will be in the future, bumps in the road. But together we are working our way through them so we can move towards the common goals of Project HERO.

As we go forward, we look forward to working together with our partners at VHA to enhance the overall contribution that the dental portion of Project HERO can make to the care provided to our veterans.

We at Delta, from the mailroom to the Executive Offices, appreciate all you have done and continue to do for the great men and women who have served our Nation. And, again, I thank you for the opportunity to appear before you today.

[The prepared statement of Mr. Henry appears on p. 73.]

Mr. MICHAUD. I want to thank you both for your testimony. It is my understanding we will have votes at noon, so hopefully we will get through the last panel. I have a couple of very quick questions.

Mr. McClain, it is my understanding that Project HERO reimburses the non-VA providers at the negotiated percentage of Centers for Medicare and Medical Services (CMS). What is that negotiated percentage? And how does that apply to all four VISNs? Because I know that each State gets different Medicare reimbursement rates. So how is it applied to all four VISNs, and what is it?

Mr. MCCLAIN. Mr. Chairman, it is a very complicated answer to a very simple question. It is different everywhere you go. Our contracted rates with the provider are not a standard in any particular geographic area. It is indeed a negotiated contract rate with the provider.

So it might be different per provider. And it is certainly going to be different across the board in all four VISNs.

Essentially under the HERO contract, we have contracted with VA to provide services by clinical numbers by what are called Contact Line Item Numbers (CLINs). And they may be different procedures. They may be several numbers connected with a particular procedure. So when the VA decides to refer that procedure out to the HERO network, it would go to our provider. The provider is credentialed by our network. They have agreed to see the veteran within 30 days. And they have agreed that the veteran will not spend more than 20 minutes in their waiting room.

After the care is delivered, the veteran returns to VA. And the provider then submits the claim for payment to Humana. So

Humana Veterans actually pays the provider our contracted rate. And then we submit claims to the VA under the HERO contract.

Mr. MICHAUD. My second question is what are the driving costs in rural areas? Is it the availability of providers?

The full Committee actually had a hearing examining how money is distributed within the VISNs. And quite frankly, when you look at some of the rural areas, I think they are getting shortchanged when receiving money from the different VISNs.

So what are the driving costs as you see so far?

Mr. MCCLAIN. Well certainly if you have very few or even only one provider in a particular area, they can drive the costs as to what they can charge for a particular procedure.

So certainly provider costs are an issue. Trying to get them under a contract is another issue. And then having some supporting infrastructure from a network point of view such as Humana's network, also there is a cost connected with that.

And so the one area that sometimes is overlooked I think in the rural costs is the cost of getting to care. In other words, the travel expenses. And I know this Committee recently passed an increase in the travel reimbursement. That now needs to be factored into the overall costs of care, no matter whether it is with VA or outside.

Mr. MICHAUD. Thank you.

Mr. Henry, in your testimony you noted that from January of 2008 to September of 2009, you received over 18,375 authorizations, which resulted in Delta Dental making 18,205 appointments. What happened to the remaining 170 authorizations? Was it because you lacked the dentist in the network to provide those, or the veteran decided they no longer needed it?

Mr. HENRY. No. The difference between the authorizations received and the appointments we make basically fall into a category of individuals who either have chosen not to make the appointment, individuals we have been unable to contact, which by the way is the largest percentage of those who don't seek the care once we have received the authorization. The next largest would be those who just made an appointment and didn't keep it.

So there is a list of—I wouldn't say problems—list of circumstances under which we would receive an authorization from the VA, attempt to make an appointment for the individual, but at the end of the day the appointment is not kept.

Mr. MICHAUD. Thank you.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. This is a quick question to both of you. I know that—well, first of all, Mr. Henry, you said—I think both of you might have alluded to that you get to see a doctor, a dentist in your case within 30 days after authorization. How long does the authorization process take?

Mr. HENRY. It would vary. Unfortunately, I would have to defer that question to our colleagues from VHA, because basically we start our clock to measure against our contract metrics once we receive it.

Mr. BROWN OF SOUTH CAROLINA. And how about once you provide the service? How long does it take to get you paid? And are you caught up in that 37 percent error factor?

Mr. HENRY. No. Since day one of the contract, we have been working collaboratively with our partners at VHA to smooth out the payment process to ensure that we bill accurately and that we get paid when we are due. And it is an ongoing process. And the best part about it is that you have two teams working together to come up with the right answer.

Mr. MCCLAIN. Mr. Brown, if I could address that also. That is one of the advantage of the Project HERO structure is that you have much fewer improper payments.

One of the issues with improper payments identified by the Inspector General's report was the fact that there had to do calculations on their part as to what the appropriate reimbursement would be for this particular provider.

Under Project HERO, there are contract rates. And so there is much less of an opportunity to have an improper or an overpayment.

Mr. BROWN OF SOUTH CAROLINA. Do you think it would be better if we went to some kind of a centralized collection system?

Mr. MCCLAIN. That is certainly something VA should look at, I believe. But I really don't have an opinion as to whether VA should move to that.

Mr. BROWN OF SOUTH CAROLINA. All right. Thank you both.

Mr. MICHAUD. Once again I would like to thank you both for your testimony this morning. I am sure that we will have additional questions in writing as well. So once again, thank you.

Our last panel is Mr. Gary Baker from the Veterans Health Administration, who is accompanied by Ms. Patricia Gheen and Mr. Craig Robinson.

I want to thank all three of you for coming today. I look forward to hearing your testimony.

STATEMENT OF GARY M. BAKER, MA, CHIEF BUSINESS OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PATRICIA GHEEN, DEPUTY CHIEF BUSINESS OFFICER FOR PURCHASED CARE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CRAIG ROBINSON, EXECUTIVE DIRECTOR AND CHIEF OPERATIONS OFFICER, NATIONAL ACQUISITION CENTER, OFFICE OF ACQUISITION AND LOGISTICS, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. BAKER. Mr. Chairman, Mr. Ranking Member, and Members of the Subcommittee, thank you for providing me this opportunity to discuss the Department of Veterans Affairs' demonstration Project on Healthcare Effectiveness through Resource Optimization or as we call it Project HERO.

I am accompanied today by Ms. Patricia Gheen, Deputy Chief Business Officer for Purchased Care, and Mr. Craig Robinson, Executive Director and Chief Operations Officer for VA's National Acquisition Center.

VA recognizes there is an ongoing need for non-VA services and that purchasing such services is a key component of our continuum of care. We understand the importance of being good stewards and carefully managing our programs for purchasing non-VA services.

We have multiple initiatives focused on improving that management. And Project HERO is a cornerstone of those efforts.

Congress directed that VA establish at least three managed care demonstration locations to satisfy a set of health care objectives related to arranging for and managing purchased care as has been noted earlier.

Project HERO is now in year 3 of a proposed 5-year pilot using a contract approach to increase the quality oversight and decrease the costs of purchased that is fee care.

This pilot is operational in VISNs 8, 16, 20, and 23. These VISNs have historically high expenditures for fee care and have substantial Veteran enrollee populations.

Through Project HERO, VA contracts with Humana Veterans Healthcare Services 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.

VA has identified the following objectives for Project HERO. Provide as much care for Veterans within VA as is practical.

We are sensitive to the issues and concerns of the VSO community and the veteran community in general and do try to provide as much care within VA as possible.

When we refer veterans, we refer them to high-quality community-based care when necessary to improve the exchange of medical information between VA and non-VA providers, to foster high-quality care and patient safety, to control operating costs, increase veteran satisfaction, secure an accountable evaluation of the demonstration project itself, and sustain partnerships with our university affiliates.

Project HERO contracts with Humana 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 a robust quality programs including peer review with VA participation, while meeting Joint Commission and other health care industry standards and requirements.

Humana uses patient safety indicators, patient complaints, and referrals as sources for initiating peer review. VA monitors contract performance, audits credentialing and accreditation, and evaluates Humana and Delta Dental performance compared to VA facilities on a range of 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.

VA has found that 89 percent of Project HERO contracted medical prices with Humana are at or below Medicare rates. And contracted rates with Delta Dental are less than 80 percent of the National Dental Registry Advisory Service Comprehensive Fee Report level.

We believe that Project HERO is meeting its objectives by improving quality oversight, access, accountability, and care coordination.

Specifically we have found that patient satisfaction is comparable to that within VA.

Costs for Project HERO are generally comparable to or slightly below VA costs for other non-VA services.

Humana and Delta Dental providers meet VA credentialing standards, quality standards, and maintain extensive quality programs.

Humana and Delta Dental provide timely access to care, providing specialty or routine care within 30 days 89 percent of the time for Humana and 100 percent of the time for Delta Dental.

Both vendors are contracted to return medical documentation to VA within 30 days. Thereby enabling VA to provide informed and continuous patient care.

While Humana and Delta Dental are not meeting this 100 percent standard, the contracts provide a vehicle for tracking medical documentation return that did not previously exist in our fee program.

We are seeing regular improvement as we work with both vendors on this particular issue. VA has worked with Humana, Delta Dental, and participating VA medical centers to make electronic clinical information sharing available to all Project HERO participating sites.

While VA recognizes the need to learn from and act upon the valuable lessons learned through Project HERO, this pilot has confirmed our ability to address key oversight issues that have been identified as a program goal.

Mr. Chairman, we appreciate the opportunity to discuss this initiative with you. My colleagues and I are available for your questions.

[The prepared statement of Mr. Baker appears on p. 74.]

Mr. MICHAUD. Thank you very much, Mr. Baker.

So do you believe that Project HERO has actually improved access to care and has led to a positive change in the quality of care provided to our veterans?

Mr. BAKER. We believe that the HERO model provides better access to care in a couple of ways, sir.

One, the concierge service, that is where our vendors make contact with the veteran and individually arrange for them to have their appointments is certainly a service that is not available in routine fee care.

Additionally, we are able to monitor that access and the timeliest of access in a way that we simply can't do for our regular fee program.

So the fact that I am able in my testimony to address the specific percentage of time in which the veteran is seen within 30 days is a reflection of the benefit that we get from the HERO contract approach.

Mr. MICHAUD. I have heard that Humana does not have access to the VA's computerized patient record system. The timely exchange of medical information, is important in ensuring a high quality of care for our veterans. Is there a reason for Humana not having this access?

Mr. BAKER. Well, VA has recognized the need for providing access to Humana so that in those instances where sufficient information isn't initially sent, they have access to the VA medical record.

We have been working through that. For longer certainly we would desire. But my understanding is if not this month, next month that access will be granted. There are security issues and a number of requirements that have to be met. We have been working through those over the last several months.

Mr. MICHAUD. And since this is a pilot program—and you heard my question to a previous panel about whether or not we might take one VISN or all four and say it mandates that they have to all go to Project HERO—my question would be, what percentage of medical care cases were referred to Humana versus the fee-based program, and similar for Delta Dental?

Mr. BAKER. Right. The aggregate number I am familiar with. We have compared that. And as a percent of overall fee care for the combination of the 2, approximately 22 percent over the last 6 months have gone to HERO as opposed to the fee program.

I also was looking at some of our statistics. And for quarter one in 2009, the number of veterans who were seen in HERO was nine percent of the number that we are seeing for fee. In quarter one of 2010, 31 percent of the veterans seen for outside care were seen in HERO as opposed to fee.

So there has been an increased utilization and penetration of our utilization of HERO. We have seen as we have continued to work with our contract partners and with the medical centers involved working to smooth out issues of referral and understanding of the program.

Mr. MICHAUD. We heard that Humana actually negotiates some of the rates with the providers. In your fee-based service, did you negotiate for those rates as well?

Mr. BAKER. If we contract for care then clearly there is a negotiation and agreed upon rate that is identified in the contract. There are opportunities as we issue individual authorizations for care for VA to identify an anticipated cost. But unless the vendor accepts that, we are required to pay them based on their bill charged and on our fee schedule, which is 75 percent of usual and customary charges.

Mr. MICHAUD. Thank you.

Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you.

Mr. Baker, you heard testimony I guess from the other panels and the concerns about how the billing was going and this sort of thing. Would you consider maybe some kind of a third-party billing to help the VISNs out?

Mr. BAKER. We have performed, actually had an outside agency perform, a review of options long term for VA in terms of its management of the non-VA purchase care program claims processing piece in particular.

That analysis included using an outside vendor, improving or purchasing a new technology for VA to use to support its processing of claims, as well as building IT systems in house. The evaluation was predicated on VA moving towards a more consolidated or centralized claims processing piece.

While there haven't been any final decisions on that, certainly we think that in the long term, there is an opportunity for VA to gain

economies of scale, and improve internal controls by consolidating and centralizing some of its claims processing activities.

Mr. BROWN OF SOUTH CAROLINA. Let me go further on this. What criteria, if any, do participating VISNs use to determine whether to use Project HERO or traditional fee basis care? And number two, does it vary from VISN to VISN? And if so, should there be consistent criteria across the four VISNs?

And then also a follow-up, too. In distributing the payment to the fee service or to the HERO service, does that come directly out of the local hospital, or is that—do you have some kind of collective fund that the—let us say under your jurisdiction that pays it? How is that?

Mr. BAKER. Payment for the services obtained through HERO are considered part of the operating budget for the individual facilities. So it is paid locally. It is not paid by any central fund per se.

In terms of the determination for whether to use fee or HERO, it is a local determination. It is one of the areas where as the program office responsible for overall coordination, we have worked to educate and worked with individual facilities to make sure they are aware of the HERO contract, the benefits of the contract.

In some circumstances, there are existing patterns of care or individual veteran desire that have an impact on where the veteran is referred. Availability of network resources for our contract partners are also a factor that is taken into consideration.

Mr. BROWN OF SOUTH CAROLINA. So in my case down in Charleston, I think we go through the Johnson VA Center, a veteran would call and get authorization then to go to a private provider?

Mr. BAKER. Generally, no. The use of and concept of HERO is that it is an extension of VA services, not something used in lieu of that.

So generally the individual is being seen by a VA provider, their care is being provided by VA, and there is a determination that they need a specialty care or diagnostic service that is not available at VA.

In that circumstance then the individual practitioner will request or recommend that the service be obtained and then there will be a decision process as to whether or not that is performed and obtained through a fee-basis activity, through an alternate existing contract, because some of our participating facilities have local contracts that had previously been negotiated, and patterns of referral, or whether they would be referred to a Project HERO provider through the HERO contract.

Mr. BROWN OF SOUTH CAROLINA. So that particular entity would have to bear the costs of the——

Mr. BAKER. The local facility bears the costs of the referral. Whether they choose to do it in-house if they have that capability, refer them to Columbia or Atlanta if they are going somewhere in the VA network. Whether they went to a contract provider, if they contracted with the local affiliate as an example. Whether they went to HERO or whether they went to a fee provider in a case where VA provided fee authorization and possibly a list of known providers who could support that care.

Mr. BROWN OF SOUTH CAROLINA. Do you think they are better served doing that than say having some kind of a central fund so

that they wouldn't look like they would be competing with their own internal budget?

Mr. BAKER. Well we think that management of health care is a local requirement. And that when you have some of your own money in the mix, you are apt to be a better financial steward in terms of managing the care and the budget for delivery of that care.

I am not sure that there was ever any intent to consider a centralized payment process for Project HERO per se.

Mr. MICHAUD. I would like to follow up on Mr. Brown's question. If you have some of your own money, it would probably be better managed.

The concern I have comes from a mini-MAC meeting I attended in Maine just recently. A concern that the VSOs had brought forward was that fee-based services in rural areas, because of the demographics, and a lack of availability of providers in rural areas, and the mileage, for instance, actually costs more.

However, under the Veterans Equitable Resource Allocation (VERA), when VA distributes the money to different regions within that VISN, if they are inadequately funded in the first place, it is going to prove problematic.

Here is an example. In Maine, for instance, we heard earlier that one of the costs is mileage reimbursement. The mileage reimbursement rate went from 11 cents to 41 cents. Now in Boston, it is a lot cheaper to go to the facility in Boston. In Maine where you have miles to go, you tend to rack up a lot of mileage.

So, for instance, Togus paid out $1.5 million in reimbursement for mileage. It cost, I believe, over $5 million. So they are operating in the red automatically, because the funding model is not adequate.

And, likewise, in rural States you have to probably do more fee-based services than you would have to in Boston, and that tends to increase costs as well.

So they will have to make a determination of whether or not they are going to have to cut back on hiring doctors and nurses or put off purchasing equipment at the medical facility, which actually doesn't help the veterans out or where we are supposed to be helping the veterans out, whether you live in an urban or rural area.

So it may not be true that having a little of their money in the process will make it more efficient, if they are not being adequately funded in the first place.

Mr. BAKER. Well, I don't profess to be the expert on the VERA allocation model. And I know that there have been discussions about that with our financial officer and others. The VERA model is an aggregate distribution mechanism. And certainly as an aggregation, there are variations based on a number of factors that when taken individually can be questionable. But I think whether or not the aggregate is equitable and provides sufficient funding is something that is being tested over time. And VA continues to try and tweak the model.

In terms of HERO per se and fee care, they are considered an integral component of managing the care of the veteran. And as such, the individual facilities are responsible for delivering that care and management.

We try to balance the needs of the individual with the available resources at our individual medical centers. And we know that there are variations based on urban versus rural, et cetera.

There was previous discussion, I think, by one of the panel members, previous panel members, asserting that HERO supports rural care and makes resources more available.

We have done some analysis there. There is some slight improvement in availability of resources and network through using HERO as opposed to straight fee. And certainly VA is very aware of rural issues and has a rural health office. We are partnering with them in working on a rural fee pilot going forward.

Mr. MICHAUD. And when is that fee pilot expected to get up and——

Mr. BAKER. We have been working with Ms. Vandenberg and her shop in terms of that. While they have the lead for that, we are providing program expertise. Part of the issue has been developing a specific criteria and some of the requirements that were in the law in terms of when exceptions can be made, et cetera.

I understand that regulatory process is in process and that those rules hope to be promulgated in the near future.

Mr. MICHAUD. Looking at fee-for-service and other issues can you tell me the driving costs in rural areas? Do you feel that the VERA model is adequate to make sure that those costs are addressed?

Mr. BAKER. I really can't give an opinion on whether VERA is adequate or not adequate in terms of rural health. Certainly the drivers for rural health have been mentioned earlier. One is access and another is simple availability.

And if there is availability, whether or not there is competition when there is availability, so that there is potential for some price competition.

Additionally, as you indicated earlier, transport of the individual, even if they have a car or ready transport, the cost of that transport has to be taken into consideration. And VA is sensitive to those both in terms of costs, but also in terms of delivering quality service to veterans and a satisfactory experience to them as well.

Mr. MICHAUD. My last question, which actually was brought up by the previous panel, is when you look at access issues and availability in rural areas and the fact that Project HERO actually negotiates for their rates, and they are based on CMS rates, have you looked at where that actually might be a disincentive, as in Maine and I am sure other States as well for providers? When you look at reimbursement rates, we have providers who are refusing to take on any more Medicare or Medicaid patients, because Medicare pays anywhere from 20 to 30 percent less than what it actually costs to provide the service. Medicaid pays only about 65 percent of what Medicare pays.

So a provider is only going to be able to operate on the fringe for so long. And we have heard that some providers are refusing to take any more Medicare or Medicaid patients.

So what are you looking at when you look at rural health care, particularly if you have to negotiate for rates? That might be a disincentive to providers that actually provide the service for our veterans.

Mr. BAKER. Right. Well, VA is sensitive to the issues of the marketplace, rural and other factors are taken into consideration. As a national strategy, we are trying to link our reimbursement schedules to CMS rates, so that their standardization helps in communication with our vendor participants and helps in terms of internal controls, et cetera.

But our authority to provide fee services and contract services allows us to exceed that standard if that is necessary for us to gain access and assure veteran access for the services that they require.

And we have examples where we contract for services and those services are contracted at rates above and in some cases well above CMS to assure that veterans have access to the services they needed. And we would expect to continue that in the future as necessary.

Mr. MICHAUD. Great. Thank you very much all three of you for your comments this morning, as well as the previous panels. I look forward to working with you as we address some of these very important issues on access and quality care for our veterans.

So without any further questions, I now adjourn the hearing.

[Whereupon, at 11:56 a.m. the hearing was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I would like to thank everyone for attending this hearing. Today, we will examine whether Project HERO (Healthcare Effectiveness through Resource Optimization) is meeting the goals of delivering efficient, high quality contract care to our veterans.

Each year, the VA spends more than $2 billion to purchase private, non-VA health care for eligible veterans. The VA has the authority to do this when VA facilities are not able to provide the necessary health care or are geographically inaccessible to the veteran. There is room for improvement in the way that the VA manages and coordinates contract care. Specifically, there is no consistent process in place to ensure that care is delivered by fully licensed and credentialed non-VA providers, that continuity of care is monitored and is part of a seamless continuum of services, and that clinical information flows back to the VA.

It is under these circumstances that the VA developed the Project HERO pilot program in response to the language in the Conference Report accompanying the VA's 2006 Appropriations Act. As the VA was in the initial stages of developing and implementing Project HERO, the Full Committee held a hearing on this issue in March, 2006. At this Full Committee hearing, the VA testified that Project HERO aimed to provide quality cost-effective care, which is complementary to the larger VA health care system. In this endeavor, the VA also testified that they would sustain on-going communication with the VSO community.

We have since learned that the VA is implementing Project HERO in VISNs 8, 16, 20, and 23. On October 1, 2007, the VA awarded the Project HERO contract to Humana Veterans Healthcare Services and Delta Dental Federal Services. We understand that the health care services became available through Humana on January 1, 2008 and that dental services became available through Delta Dental soon thereafter on January 14, 2008.

With nearly 2 years of rich program data, our hearing today will examine whether the VA has delivered on the promises of Project HERO. For example, was Project HERO implemented properly to meet the pilot program's objectives to provide improved access, quality, and cost-effective care? Was there transparency in the implementation of this pilot program and was the VSO community informed and involved? Finally, what has Project HERO achieved and what are the potential next steps moving forward?

To help us answer these questions, I look forward to hearing the testimonies of our witnesses.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you Mr. Chairman.

I appreciate your holding this hearing today to examine how well the Department of Veterans Affairs (VA) is providing health care to our veterans within their communities—when a VA facility is too far from a veteran's home or a service is not available within VA.

The use of local, non-VA providers offers greater access to services and is vital to ensuring that our veterans get the care they need in a patient-centered manner. Known as the fee-basis program, VA spent over $3 billion dollars last year, with more than half of this spending for outpatient care.

Recognizing the size and scope of the fee-basis program, in 2006, Congress directed VA to establish a pilot program to better manage the care VA purchases. In response, VA developed Project Healthcare Effectiveness through Resource Optimization or Project HERO.

The purpose of the Project HERO pilot program is to more effectively refer and better coordinate fee-basis care, improve the exchange of information between VA and community providers, and increase veteran patient satisfaction.

As we enter the third year of the Project HERO pilot, it is important that we take a critical look at the implementation of the pilot—its successes and challenges.

VA does not have a standardized method to monitor fee-basis care, outside of Project HERO. And, it is very troubling that a VA Office of Inspector General audit of VA's outpatient fee care program last August revealed significant payment errors and oversight vulnerabilities.

I look forward to hearing from our witnesses today and to examine how to strengthen controls over VA's fee-basis program to ensure both high quality care and good management and oversight.

Thank you Mr. Chairman, I yield back the balance of my time.

Prepared Statement of Denise A. Williams, Assistant Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the Department of Veterans Affairs (VA) health care contract program known as Project HERO. These views are based on quarterly update briefings given to Veterans' Service Organizations (VSOs) by VA as to status of the Project HERO project.

In 2007, VA began the Project HERO (Healthcare Effectiveness through Resource Optimization) program as a pilot study. This study, at the direction of Congress, required VA to examine and execute health care management strategies. The strategies captured were deemed a success in the private and public sector. The overall purpose of the program was to closely manage health care services purchased by VA. Project HERO, now in its second year of a 5-year pilot to increase the quality of care and decrease the cost for fee care, is currently available in four Veterans Integrated Services Networks (VISNs): 8, 16, 20, and 23.

In accordance with congressional oversight, health care purchased for veterans from the private sector providers must be secured in a cost effective manner that compliments the Veterans Health Administration (VHA) system of care as well as maintains a strong affiliation with medical universities throughout the VA system.

VA's objectives for Project HERO included:

- increase the efficiency of VHA processes associated with purchased care from outside sources;
- reduce growth of costs associated with purchased care;
- implement management systems and processes that foster quality and patient safety;
- make contracted providers virtual, high-quality extensions of VHA;
- control administrative costs and limit administrative growth;
- increase net collections of medical care revenues where applicable; and
- increase enrollee satisfaction with VHA services.

The American Legion is concerned with quality of care, the timeliness of access to care, and patient satisfaction. The stated goals of Project HERO deal with managing the "fee based" health care services. If I may paraphrase, "In order to streamline the process, reduce cost, and insure security of records, of contracted health care." In briefings received by VSOs from VA, these goals seem to be in reach.

The American Legion reiterates the priority need is for quality health care in a timely manner to be provided. Currently, Project HERO sets up appointments with "certified" caregivers. It is our opinion that VA should increase its efforts to enforce criteria for the certification of caregivers, do follow-up investigations, and conduct training to assure care given by contracted caregivers meets the quality of care standards received at a VA facility. This oversight would not only assure quality health care, but it will improve customer satisfaction in the overall process. That is, once caregivers are VA "certified" the need for extended review of recommended treatment by VA experts, as is now the case, would not be necessary.

The American Legion recommends that under Project HERO, VA consider mirroring the Private Sector's approval practices for treatment between doctors and insurance companies; allowing veterans to have timely access to quality health care as opposed to waiting for an extensive VA review of the recommended treatment. Since patients would only be sent to "VA approved and certified" commercial facilities for treatment, it would be generally accepted that recommended procedures be allowed and conducted. These treatment procedures should be reviewed after

patients are treated. If it is found that excessively expensive or unnecessary treatments have been preformed, the service provider should be charged back or decertified for repeat infractions.

As the Department of Defense (DoD) turns to the Reserve components for additional manpower, the number of veterans residing in rural and highly rural areas significantly increases. Veterans from Operation Enduring Freedom and Operation Iraqi Freedom are authorized enrollment in VA's health care delivery system for 5 years after separation. Clearly, veterans in rural and highly rural areas continue to be underserved. These veterans should not be penalized because of their choice of geographical location. The American Legion urges VA to improve access to quality primary and specialty health care services, using all available means at their disposal, especially for veterans living in rural and highly rural areas.

While not originally designed to address rural health care, initial results from the four VISNs in the pilot project indicate that Project HERO process could in fact be an important component to addressing this health care access issue.

The American Legion urges VA to expand access to Project HERO to veterans in other VISNs particularly those VISNs with extensive rural veteran's populations or limited access to VA facilities, such as Alaska and Hawaii. This is to assure that veterans residing in areas with limited access to VA medical facilities are not subjected to insufficient health care. Knowledge and understanding of existing programs by veterans is critical to success. The American Legion urges that every measure be taken to assure these advances are communicated and implemented within the most rural and highly rural areas to provide all veterans with timely access to quality health care in the proper settings.

Finally, The American Legion would like to emphasize that this program should not be utilized as a means to control the VA Medical Center's budget by referring veterans to Project HERO resources in order to save on equipment repair or purchases. For example, if the emphasis on cost savings becomes too great, we could see a scenario where an administrator would delay repair or purchase of a piece of equipment, justifying it by utilizing Project HERO health care and thereby enhancing budget numbers. We would like to encourage VA to continue to maintain a health care delivery system which 8 million veterans rely on for their care. It is imperative to note that the Project HERO should not be intended to replace the VA health care system.

Mr. Chairman and Members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues on this important matter.

That concludes my written statement and I would welcome any questions you may have.

Prepared Statement of Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this important oversight hearing of the Subcommittee on Health. DAV is an organization of 1.2 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

The DAV appreciates your leadership in enhancing Department of Veterans Affairs (VA) health care programs on which many service-connected disabled veterans must rely. At the Subcommittee's request, the DAV is pleased to present our views on the VA's Health care Effectiveness through Resource Optimization (HERO) project. This demonstration project was directed to be carried out by the Conference Report on VA's fiscal year (FY) 2006 appropriation, Public Law 109–114. Congress deemed it essential that care purchased from private sector providers for enrollees of the VA health care system be secured in a cost effective manner, in a way that complements the larger Veterans Health Administration (VHA) system of care, and preserves important agency interest, such as sustaining a partnership with academic affiliates.

As this Subcommittee is aware, the Department revamped the Project HERO solicitation from its original form and later awarded a contract in October 2007 to Humana Veterans Health care Services (HVHS), a national managed care corporation that was a major fiscal intermediary and private network manager under the Department of Defense (DoD) TRICARE program. In January 2008, contract services for dental care were to be made available through Delta Dental. Under this demonstration, participating Veterans Integrated Services Network (VISNs) are to provide primary care and, when circumstances warrant, must authorize referrals to

HVHS for specialized services in the community. These specialty services initially included medical/surgical, diagnostics, mental health, dialysis, and dental.

VA indicated VISNs 8, 16, 20 and 23 were selected as they had the highest expenditures for community-based care, particularly relative to the number of enrollees in the VISN. In addition, these VISNs are some of the larger VA networks, together representing 25 percent of total enrollment and 30 percent of annual out of network expenditures. These selection factors were used to ensure the demonstration results are representative of the larger VA population and to facilitate measurement of proof of concept under Project HERO. Contracts for this demonstration project have a base year and 4 option years. Having recently exercised the second 1-year option, the demonstration project is now on its third year.

DAV believes Project HERO is timely considering the escalating rise in spending for non-VA purchased care and the manner by which such care is managed. According to VA, total expenditure for VHA Fee Basis programs in FY 2007 was $2.227 billion.[1] VA spent approximately $3 billion in FY 2008 in non-VA purchased care and estimates it will spend $3.8 billion for FY 2009.[2] Despite the growth of the program, well known weaknesses in VA's fee-based care program remain and have been subject to criticism by the veteran community,[3] VAOIG,[4] and the GAO.[5,6] For example, VA does not track fee-based care, its related costs, outcomes, access, or veteran satisfaction levels.[7,8] Also, unlike the contract's medical reimbursement prices under Project HERO, VA's fee-based care program is highly decentralized, lacks sufficient guidance, and subsequently suffers from wide variation in reimbursement prices for both facility and professional charges.

Mr. Chairman, we mention this because in testimony before the Senate Committee on Veterans' Affairs on September 30, 2009, VA has begun to compare Project HERO to fee-based care.[9] Our concern here is that VA's fee-basis care program sets such a low bar that a comparison to any other non-VA purchased care program would excel almost by default. We believe the objectives outlined by Congress address similar concerns DAV has that VA has no systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

If Project HERO is to achieve all of the above, the result could offer our Nation's veterans a truly integrated, seamless health care delivery system, improved veteran satisfaction, and optimized workload for VA facilities and their academic affiliates while cost for non-VA care is reduced. For the hearing today, we wish to share with you key features of Project HERO that DAV believes are important for your consideration.

Patient Safety and Quality of Care

Mr. Chairman, the reality of veterans who are enrolled in the VA health care system and receive care purchased by VA is that they lose many safeguards built into the Department's system through its evidence-based medicine, electronic medical records, and bar code medication administration. VHA's health care quality im-

[1] Department of Veterans Affairs, Veterans Health Administration Directive 2009–033, Resolving Adverse Credit History Reports for Veterans Receiving Late Payments for Purchased Non-VA Care, July 15, 2009.

[2] Joseph A. Williams, Jr., Acting Under Secretary for Operations and Management, VHA, testimony for hearing on "VA's Contracts for Health Services" before the Senate Committee on Veterans' Affairs, September 30, 2009.

[3] The *Independent Budget* for Fiscal Year 2010.

[4] Department of Veterans Affairs Office of Inspector General, Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, August 3, 2009.

[5] Government Accountability Office, VA Health Care: Third-Party Collections Rising as VA Continues to Address Problems in Its Collections Operations, January 31, 2003.

[6] Government Accountability Office, VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans, July 14, 2009.

[7] Washington D, "Ambulatory Care Among Women Veterans: Access and Utilization," VA Office of Research & Development, Health Services R&D Service, November 2008.

[8] Elizabeth Yano, "Translating Research Into Practice—Redesigning VA Primary Care for Women Veterans," PowerPoint Presentation, DAV National Convention, Las Vegas, NV, August 2008.

[9] Ibid.

provements over more than a decade have been lauded by many independent and outside observers, including the Institute of Medicine of the National Academy of Sciences, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum, and the Agency for Health Care Quality and Research (AHRQ) of the Department of Health and Human Services. In addition, VHA emphasizes a culture of safety by allocating resources toward establishment of special centers, enhancing employee education on patient safety, and providing incentives to promote safety. Its voluntary adverse event reporting system allows the reporter to remain anonymous and VHA's patient safety initiatives and reporting on systems issues associated with adverse events are used to improve its own patient safety programs.

These unique features culminate in the highest quality care available, public or private. Loss of these safeguards, which are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and, ultimately, may result in lower quality of care for those who deserve it most.

Having communicated these concerns to VHA since the early stages of developing the concept of this demonstration project, VA has continually assured the veteran community that the quality of care provided through Project HERO would be equal to or better than the care provide directly by VA. To follow such assurances, Project HERO contracts require HVHS and Delta Dental to meet VA's patient safety and quality of care standards, which include:

- HVHS and Delta Dental providers must be credentialed;
- HVHS providers under Project HERO must practice in facilities accredited by JCAHO, or one of the following: the Commission on Accreditation of Rehabilitation Facilities, the Intersocietal Commission for the Accreditation of Vascular Laboratories, or the American Osteopathic Association;
- Establish a process for reporting patient safety, complaints, and satisfaction; and
- Utilize a peer review process within HVHS with VA participation for any such reported cases.

The DAV believes these standards as required by VHA are an important step in the right direction to acquire high quality health care from the private sector, and should be part of all non-VA purchased care. However, if this demonstration project is to complement the VA health care system, patient safety and quality of care under Project HERO will continue to remain a concern of DAV until such time as it is determined that the required standards and processes listed above yield care that is in fact equal to or better than the care directly provided by VA.

In addition to Patient Safety and Quality of Care, DAV has chosen to focus on specific domains regarding Project HERO: Patient Satisfaction, Access to Care (distance and timeliness), and Clinical Information Sharing. We understand these areas are directly affected by workload, which we have included in the table below. From January 2008 through May 2009, comparing Project HERO to fee-based care on the number of patients served and the number of services paid in each program, VISN 16 is the highest user of Project HERO services, followed by VISN 23, VISN 20, and VISN 8.

	Service Items Paid			Number of Patients		
	Other Fee	**Project HERO**	**Percent**	**Other Fee**	**Project HERO**	**Percent**
VISN 16	751,193	52,474	6.99%	53,544	13,430	25.08%
VISN 23	586,673	33,980	5.79%	48,785	5,787	11.86%
VISN 20	388,543	15,446	3.98%	35,734	4,099	11.47%
VISN 8	724,632	6,302	0.87%	77,516	5,765	7.44%
TOTAL	2,451,041	108,202	4.41%	162,035	15,651	9.66%

Patient Satisfaction

Questions from VHA's Survey of Healthcare Experiences of Patients (SHEP) are being used to determine patient satisfaction for Project HERO. While HVHS providers received a 79 percent average rating from veterans who indicated the "overall quality of visit" was very good or excellent and Delta Dental providers received an 85 percent average rating, we would like to point out the low scores ranging from 54 to 61 percent among the four VISNs for the same survey question. Interestingly, the trend for patient satisfaction scores for outpatient HVHS services have been in-

creasing over FY 2009 as volume of authorized services has decreased (but the number of patients served has increased from about 6,000 to over 15,500 and the amount disbursed to HVHS roughly $5 million to $12 million). Unfortunately, even though the volume of authorizations for Delta Dental services has been declining since the beginning of FY 2009 (veterans served rose from 2,286 to 3,303 and the amount disbursed from about $2.5 million to $4 million), the overall satisfaction for Delta Dental care has been declining.

When determining how satisfied patients were with regards to the location of HVHS, Delta Dental, and VA facilities, surveys indicate patients are overwhelmingly satisfied with the location of Delta Dental facilities when compared to VA and HVHS facilities in all four VISNs. VISN 20 is the only region for which patients are more satisfied with the location of VA facilities versus HVHS. However, as the table below indicates veteran satisfaction for contractor's facility locations are comparable to VA across all four VISNs, the trend through May 2009 in rating the convenience of their locations has gone down.

Patient Satisfaction with Facility Location				
	VISN 16	**VISN 20**	**VISN 23**	**VISN 8**
Project HERO HVHS Outpatient	87%	89%	83%	82%
Project HERO Delta Dental	95%	96%	98%	90%
VA—SHEP	89%	86%	91%	87%

It should be noted that, unlike SHEP, which is aimed at overall quality throughout the year in 12 VA service areas, including access to care, coordination of care, and courtesy, Project HERO patient satisfaction is based on only one episode of care. The IBVSOs encourage VA to ensure such comparisons are indeed valid and to separate these comparisons for each of the four VISNs and by specific survey questions rather than the average.

Access to Care

While it is an intensive exercise, VA is able to determine access to care by distance. Moreover, VA is able to determine by survey a veteran patient's satisfaction with travel time. According to VA, Project HERO patients travel roughly the same distance (27.44 median miles) as patients under the Department's fee-basis program (29.81 miles). No data for travel to VA facilities has been provided. For FY 2009 to date, 95 percent of respondents rated the convenience of the Delta Dental location as good, very good or excellent, 85 percent rated HVHS, and 88 percent rated VA facility locations similarly. No data for patient satisfaction with travel to VA facilities has been provided.

Project HERO contract providers are also obligated to meet timeliness access-to-care standards that include appointment scheduling within 5 days, completing appointments within 30 days (once all information needed to authorize the care is provided by VA), and veteran patient office wait time of 20 minute or less. Data for the latter standard is gathered by survey and results indicate both HVHS and Delta Dental continue to meet or exceed VA's performance to see the patient once at the provider's office within 20 minute or less. Delta Dental's compliance to provide care within 30 days has a median of 99.7 percent, whereas HVHS has 88.5 percent. Unfortunately, we do not have information on the four VISNs' own compliance for either VA provided care or other non-VA purchased care to compare the appointment scheduling within 5 days, completing appointments within 30 days, and veteran patient office wait time of 20 minute or less.

DAV appreciates VA's concern over and actions taken regarding patients traveling farther for care under Project HERO than what is available for fee care. We would like to highlight that under Project HERO, VA is now able to capture timeliness of care data that VA purchases from the private sector through Project HERO.

Clinical Information Sharing

Contracts require clinical information sharing and timelines be adhered to for each episode of care. HVHS and Delta Dental are to receive all necessary clinical information of the patient to complete the requested medical care from the authorizing VAMC. HVHS and Delta Dental are to upload the patient's clinical data, which includes digital images and/or scanned clinical notes and treatment plans for services rendered, to a secure server site. The referring VAMC's fee claims office downloads patient medical records from the secure server site, sends the clinical information to its Health Information Management Service (HIMS) and attaches these records to the consult in VA's Computerized Patient Record System (CPRS).

Clinical inpatient and outpatient data generated as a result of referral to HVHS and Delta Dental for authorized care is to be provided to the VAMC within 30 days of the appointment date or inpatient discharge date. With 30 days for the appointment to be completed and 30 days to return the clinical information, this metric has a lag time of approximately 60 days. HVHS radiology reports are to be electronically signed within 48 hours, and initial treatment plans from Delta Dental are to be submitted to VA for approval within 10 days.

On average, HVHS compliance in FY 2009 for returning within 30 of "inpatient care" and "routine and diagnostic" clinical data had been 82 and 86 percent respectively. The average HVHS compliance for returning "radiology reports" within 48 hours has been 89 percent. Delta Dental had a 70 percent average compliance for FY 2009 for submitting initial treatment plans to VA within 10 days. According to VA, submission of initial treatment plans is not a normal procedure for dental treatment in the community resulting in the consistently low compliance with this requirement.

While much work needs to be done to ensure contractors meet compliance standards, the efforts by all parties to make this a key performance measure in Project HERO should be commended. All participating VA facilities have electronic clinical information sharing available with HVHS and Delta Dental—unheard of in other non-VA purchased care programs. Moreover, HVHS is to have read-only access to VA CPRS by the end of January 2010. DAV applauds VA for piloting a program to electronically share through a secure Web site scanned radiological images performed by Delta Dental as well as piloting at limited sites read-only access to VA's electronic health records by the contractors. However, DAV believes electronic clinical information sharing is an important component to contract care coordination. Since meeting these contract standards is one component to consider in exercising optional years beyond the current contract, we expect HVHS and Delta Dental to continue its upward trend to meet these targets and if not, VA should take appropriate action.

Cost Analysis

Mr. Chairman, some concern have been raised about the "Value Added Fee" for additional administrative services performed by HVHS and Delta Dental. These services include credentialed providers, accredited facilities, return of clinical information to VA, timely provider claims processing and transmission to VA for reimbursement, monitoring and reporting of access to care, appointment timeliness, patient safety and satisfaction, coordinated appointment-setting services and other patient advocate services.

The DAV believes these costs should be included in any cost analysis performed for Project HERO. Indeed these may not be actual medical care per se; however, it is an inextricable part of the overall quality and coordination of care provided to veteran patients in this demonstration project. VA has indicated its contract pricing is comparable to or lower than market rates; however, when factoring in the value-added fee per claim, aggregate price exceeds market rates. Moreover, while we have limited information about VA's claims auditing procedures, but appears in need of refinement to minimize the risk of overpayments. Thus, our fear remains that under this demonstration project, VA will pay significantly more for contract care without the safeguards of VA's high quality standards.

Impact on VA Facilities and Affiliates

VA has chosen to measure any impact Project HERO may have on VA facilities within the VISNs 8, 16, 20, and 23 and their academic affiliates by reporting on "VHA full-time equivalent employees in Project HERO VISNs" and the "volume of authorizations to academic affiliates." To date, we are waiting for data from VA in order to determine whether such reporting accurately measures whether or not important Departmental interests are preserved, such as sustaining a partnership with university affiliates, and that Project HERO complements rather than supplants the larger VHA system of care.

Conclusion

Mr. Chairman, as DAV testified before the full House Committee on Veterans' Affairs in March 2006, VA's unmanaged programs in purchased care were not only expensive and growing but were entirely discontinuous from VA's excellent internal health care programs and were absent the numerous protections and safeguards that are the hallmarks of VA health care today. DAV believes that more proactive management of fee and contract services by VA can provide greater continuity of care for veterans, better clinical record-keeping, higher quality outcomes and reduced expense to the Department.

The delegates to our most recent National Convention passed Resolution No. 232 to improve VA's purchase care program. Under this resolution, DAV urges Congress and the Administration to conduct strong oversight of the non-VA purchased care program to ensure service-connected disabled veterans are not encumbered in receiving non-VA care at VA's expense. Furthermore, the resolution urges VA to establish a non-VA purchased care coordination program that complements the capabilities and capacities of each VAMC and includes care and case management, non-VA quality of care and patient safety standards equal to or better than VA, timely claims processing, adequate reimbursement rates, health records management and centralized appointment scheduling.

VA has demonstrated through Project HERO its ability to deliver on the ideas we expressed previously and still now to improve VA contract care coordination:

1. Oversight of clinical care quality is provided by the contractors and care is delivered by fully licensed and credentialed providers and must meet VA-defined quality standards;
2. Coordination of care is performed by the contractors by communicating directly with the veteran and prospective provider;
3. Continuity of care is monitored by the contractors and VA as patients are directed back to the VA health care system for follow-up when appropriate; and
4. Clinical information necessary to provide the care under Project HERO is provided by VA to the contractors, and records of care are scanned by the contractors and sent to VA for annotation in its Computerized Patient Record System (CPRS).

Unfortunately, this list is not complete and thus our concerns remain. Since this matter first emerged in the FY 2006 Congressional appropriations arena, it has remained a significant concern that Project HERO, as with all other non-VA purchased care programs, does not become a basis to downsize or to privatize VA health care. To that end, DAV would like to express our appreciation for VA's effort to address our concerns and those of the veteran community. However, as indicated in our testimony, VA's goals for the Project, while laudable, require greater specificity to include validated and comparable data. The quarterly updates VA has provided to the veterans service organizations have been informative and DAV is working closely with VHA's Chief Business Office to ensure these reports provide more consistent and meaningful data.

As DAV continues its work to ensure Project HERO achieves the goals we have advocated, we encourage this Subcommittee to continue its oversight, which would help ensure this demonstration project will provide a model for contract care coordination. This concludes DAV's testimony and I would be pleased to address your questions, or those of other Subcommittee Members.

Prepared Statement of Thomas Zampieri, Ph.D., Director of Government Relations, Blinded Veterans Association

INTRODUCTION

Chairman Michaud, Ranking Member Congressman Brown, and Members of the House Veterans Affairs Subcommittee on Health, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present our testimony today on the Healthcare Effectiveness through Resource Optimization Project "HERO." BVA is the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our Nation's blinded veterans and their families for over 64 years.

The Veteran Service Organization *Independent Budget* (VSOIB) stresses how important and critical it is that VA solve the growing problem of contracted care from the old fee basis services system into a more coordinated, high quality care system with improved access, and cost effective delivery of those services for veterans. Along with this, any contracted care must eventually ensure full development of bidirectional compatible Electronic Health Record (EHR) where VA clinicians can immediately access all contracted care clinical notes or diagnostic services provided by contractors. These changes will improve the coordination of care plans between VA and private providers. BVA also believes that contracted care must not negatively impact current VA clinical capacity or existing specialized rehabilitative or academic affiliated training programs. The VA track record on the fee basis billing has not been good and we point to the recent VA OIG Report No 08–02901–185 released August 3, 2009 "Audit of Veterans Health Administration's Non-VA Out-

patient Fee Care Program" as evidence of the problems associated with the current contract system.

During 4-year period of fiscal years FY 2005–2008, outpatient Fee Care Program costs have more than doubled from $740 million to over $1.6 billion and in FY 2008 VA paid about 3.2 million out-patient fee claims. VA IG reports, "made significant number of improper payments (37 percent of paid claims reviewed), such as duplicate claim payments, and incorrect payment amounts." If the current contracted Fee programs have these issues, BVA requests assurances that the diversion of funds into the on going HERO project has full transparency and accounting of the total costs. Of concern is reports from local VA medical facilities of complaints that VA centers are having budgetary related staffing problems today, even after the large increases provided by this congress. One fear is expansion of contracted services hurts VA internal staffing more as more care is outsourced. While we appreciate that VHA business office staff have provided regular briefings to the VSOs about the status of Project HERO, there has certainly been concerns on information regarding total costs, types of health care provided to veterans ranging from primary care services verses expansion into specialist care, and what will determine which veterans are further enrolled (other than four VISN networks general geography being the deciding point). There should be further questions of VA about how Project HERO is going to evolve in the next year. Some should today still ask "Why was only one large contractor used for all four VISN networks instead of two or more managed care competitive organizations for comparison purposes of access, quality outcomes, clinical care costs, and meeting VA contract goals?" VHA started the contract of outsourcing services for Project HERO with Humana in 2007 with this 5 year pilot now half way completed with some questions about if this meets the needs of VA for contracted care for evaluation purposes.

In the midst of leadership changes now in VHA we stress accountability and transparency as essential for this health care program before any further decision is made on contracted care services. We notice one report that some 27 percent of all CBOC's now are contracted medical staffed clinics along with what Project HERO is performing for VA. In rolling out this project, some frequently referenced the section of the *Independent Budget* (IB) that recommended changes in the fee-basis system and current contracting of services as the justification. Nevertheless, the IB recommended that "contracted care be used judiciously and only in specific circumstances when VA facilities are incapable of providing the necessary care or geographically inaccessible to the veteran, and in certain emergency situations so as not to endanger VA facilities' ability to maintain a full range of specialized services for all veterans." The idea behind Project HERO now at times seems to be advancing towards enrolling as many veterans in entire geographical regions into managed care for medical services possible. This idea is different from the concept of improving the current system with Preferred Providers so that VA's integrated clinical and claims information technology system becomes efficient, cost effective, and with high-quality processing.

The IB stressed that participating preferred providers should use a provider pricing program to receive discounted rates for services rendered to veterans with only credentialed, high quality providers utilized in contracted care. Customized provider networks should complement the capabilities of and capacity of each VA Medical Center and not replace those ever as the veterans' first choice of care. The VA health care system has undergone tremendous positive changes in the past decade, bringing it recent high acclaim for its leadership in quality and for its outstanding utilization of information technology EHR in advancing health care for our Nation's veterans.

What veterans request from Congress is the ability to obtain local primary care services in certain geographical locations if no VA-based outpatient services currently exist and those providers have the technological ability to interact with the VA facility that has provided them with other specialized services, medications, or diagnostic care. Having an elderly or disabled veteran who has difficulty traveling long distances for VA care receive locally contracted care and preventative medical services is an extremely different proposition than opening "enrollment of veterans in a widespread geographical area" to managed-care organizations. In an industry in which CEOs search for competitive advantages in the marketplace, one must ask why there were so many for-profit health care management organizations lined up initially in a bidding contest for the main contract—unless of course the profit margins—were going to meet the needs of the bottom line as a first priority. Now that in 2009 all contracted VA services is going over $ 3.4 billion it is a growing economic target of opportunity especially with proposed large Medicare managed care cuts inserted into health care reform.

Reforms have been implemented by private, for-profit managed care health organizations outside of VA during the past couple of decades and these reforms, some critics would argue, have caused consumer revolts. The critics also claim that such reforms have forced many new Federal and State regulations, more tort claims, rising inflation rates of 11 percent in 2003–2004 period premiums, growing deductibles, and an increase in for-profit corporate mergers. Strategic plans are frequently based on the best economic interests of investors, not the consumers. Stories of health care providers within HMOs being forced to order profitable laboratory or technological tests in order to increase revenue have not been uncommon. Demands to increase productivity by mandating minimum numbers of daily encounters in order to generate sufficient revenue have also occurred. VA administrators may claim that these are outside private sector issues, but we recommend careful consideration of this track record, while VA moves closer to this method of care in the next couple years.

With Project HERO we do applaud that the Program Management Office (PMO) monitors quality by access to care, provider credentialing, facility accreditation, clinical information sharing patient satisfaction surveys, and peer reviewed triggers for safety. There is high level of Clinical Quality Management oversight on the care provided and frequent meetings between HVHS, Humana, and VA on reviewing the services provided is good news. Satisfaction rates from surveys are reported to be at 77 percent from veterans surveyed slightly higher than VA care surveys. The average disbursed amount per outpatient is $1,064 for Project HERO and higher $1,782 for other Fee Service care is a positive sign in the reports we have received.

VA is confronted with extremely complex medical-social service challenge, in the face of American health care reform before congress today. With an aging veteran population with multiple conditions along with the returning war wounded requiring specialized resources and the requirement to meet rural health care access demands of veterans, while improving quality and increasing enrollment. These are all difficult challenges, with long-term co morbidities and unique mental health problems, the triad of access, cost, and quality continues. These challenges abound within the environment of the VA budgeting system and we thank the Members of this Congress for passage of Advanced Appropriations, as one step to lower stress on the system. Project HERO may show some cost savings with Humana but this requires more assessment. Reforms driven by cost-conscious market forces without adequate oversight are often complex, chaotic, and disabling to those caught up in these changes. According to the "chaos theory" a small change in input can quickly translate into overwhelming differences in output. As has already has been demonstrated in this country's history, any changes in the three basic tenets of health care delivery—quality, access, and cost—results in significant changes in one or more of the others.

RECOMMENDATIONS

VA should establish a contracted care coordination program that incorporates the Preferred Pricing Program based on principles of sound medical management and to meet veterans' specific needs for services.

The components of a care coordination program should include claims processing, health records management, and centralized appointment scheduling. VHA must establish current and comprehensive policies and procedures, core competencies with training for fee staff, and clear oversight procedures for the Fee Program.

Veterans' electronic medical records are properly updated with data regarding any care provided by non-VA providers so records are fully integrated, there is seamless continuum of care that facilitates improved health care delivery and access to quality care.

Contracted health care services must be able to move a veteran from outpatient clinic care to ambulatory care diagnostic services, and into all other VA medical care service, while avoiding fragmentation of the care. VA also should develop a series of tailored pilot programs to provide VA-coordinated care in a selected group of rural communities. As part of these pilots, VA should measure the relative costs, quality, satisfaction, degree of access improvements, and other appropriate variables, as compared to similar measurements of a like group of veterans in VA health care. Local VAMC budgets for staffing must be maintained and contracted costs should be incorporated into VISN budgets to prevent internal cuts in services for veterans dependent on the VAMC.

In addition, the national Preferred Pricing Program's network of providers should be leveraged in this effort. Each pilot also should be closely monitored by the VA's Rural Veterans Advisory Committee. These same pilots can in turn be tailored to create a more formal surge capability addressing future access needs.

Congress should request GAO study assessing the effectiveness of contracted care services, costs analysis, VA impact on staffing, and provide evaluation of the efficiency of Project HERO is meeting goals in FY 2010.

The VHA provides a uniform medical benefits package to all enrolled veterans, regardless of their enrollment priority group, that emphasizes preventive and primary care, and offers a full range of outpatient and inpatient services and prescription medications. Accordingly, enrollment in the VHA health care program must be considered acceptable health care coverage and VA protected in any health care legislation before congress, in the same manner as members of the uniformed services and their dependents, including Civilian Health and Medical Program of the VA (CHAMPVA) coverage furnished under section 1781 of title 38 United States Code, so that they will not be subject to any tax or penalty for lack of health care coverage. Further the VA should be protected from other federal agencies administration of new health care panels or exchanges. We require that specific language is inserted assuring protection of the VA system of health care.

CONCLUSION

Once again, Mr. Chairman, thank you for this opportunity to present our testimony on Project HERO. Health care problems confronting the Nation are complex and are going to continue to be cause of heated debate in this session and the VA will be impacted just like Medicare, Medicaid, along with the uninsured, regardless of how the final bill is written. The future of managed-care organizations, once considered the answer for many of the health care issues 20 years ago has dimmed considerably as rising costs still dominate every aspect of the system and the numbers of uninsured hit estimates of 49 million. Veterans who served and defended this country deserve to be guarded from being increased market shares. BVA again expresses thanks to the Committee for this opportunity to present our testimony and will answer any questions you have.

Prepared Statement of Bernard Edelman, Deputy Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Good morning, Chairman Michaud, Ranking Member Miller, and other Members of this distinguished Subcommittee. Vietnam Veterans of America (VVA) thanks you for holding this very important hearing today, and we appreciate the opportunity to offer our views on Project HERO.

Project HERO, as you know, was born of a congressional mandate in Public Law 109–114, the Military Construction, Military Quality of Life and Veterans Affairs Appropriations Act of 2006, for the Department of Veterans Affairs to get a handle on the expenditures out of the VA system for veterans health care by establishing a comprehensive managed care demonstration program in at least three VISNs. While the amount spent outside the system varies from VISN to VISN, and the cost per service varies dramatically, it totals at least one out of every 10 dollars spent by the VA on health care—not an insignificant amount of money—and Congress was concerned, correctly, that a lot of this money was not properly tracked, nor was there any evidence of efforts to standardize costs and secure the most quality service for the best price.

The VA, to comply with this mandate, initiated in four VISNs what was conceived as a 5-year pilot cleverly dubbed Project HERO, its acronym for Healthcare Effectiveness through Resource Optimization. With shooting wars ongoing in Afghanistan and Iraq, "HERO" had a nice, patriotic ring. Of course, this only served to raise our suspicions about what the VA was planning to do and how they were planning to do it.

VVA was concerned then that the pilot project would not fill in the gaps in care, e.g., for veterans living in rural or remote areas of the country, or in emergency situations, such as when a VA Medical Center's MRI breaks down.

Our suspicions were further incited initially when VA officials shared with the VSOs a list of companies, many of them small veteran-owned businesses, which were interested in bidding on the contract. We felt that this was an attempt to quell our concerns or objections; after all, this could mean government contracts for these businesses, which too often are shut out of such contracts because of a variety of roadblocks.

As you know, it turns out that Humana and Delta Dental, two large entities, won the contracts. This was hardly a surprise. What was a surprise, however, was that Humana, certainly, did not have in place the network of providers in the areas, the

rural and remote areas of the VISNs, in which the VA was hard-pressed to provide health care services on a timely basis.

After 1 year spent recruiting clinicians for its networks, several of whom, we believe, had already been providing fee-basis health care to veterans, Humana seems pretty well geared up. But many of its providers appear to be located pretty close geographically to the VAMCs whose services they are supposed to supplement. So the question is: Are the health care services rendered by Humana, and by Delta Dental, "enhancing" the health care at the VAMCs and CBOCs? Further, while this project was supposed to "fill in" services when VA had trouble recruiting key specialties for a reasonable time, is there is indication that the "temporary" fixes have now become permanent, and that VHA is no longer trying to fill the vacancies on its own staff at the relevant VAMC? And are they succeeding in filling in the gaps in VA service at a significant cost saving to VA?

We are not convinced that they are.

During our quarterly briefings with VA officials, we are given thick reports festooned with charts and graphs and lots of numbers. What we are not given is any real evidence that HERO is enhancing care available at VAMCs and/or CBOCs. What seems to have evolved is a parallel health sub-system in these VISNs. What was supposed to supplement VA health care seems to be supplanting basic care—and not only in rural and remote areas. This was not, we believe, the intent of Congress.

Through the fiscal largesse of Congress for VA health care operations over the past 3 years, it seems to us that rather than pay a middleman, which is what Humana and Delta Dental in essence are, the VAMCs and VISNs ought to be able, on their own, to get a handle on dollars for doctors and other clinicians whose fee-basis services are necessary for the provision of timely health care to veterans who either reside inconveniently away from VA facilities or who cannot get appointments in a reasonable amount of time, either with primary care providers or with specialists.

VVA sees no reason why internal units at VISNs and VAMCs can't assemble a roster of clinicians and "regulate" fee-basis care, insuring that such care is available, of high quality, and can be integrated into the VA's electronic health record system.

Just as important, as we have written in the past, the entire business model of HERO threatens the underpinning of the VA health care system. VISN and VAMC directors can find it is fiscally advantageous in the short term to outsource more and more of their services. This can, and we believe will, eventuate in the shuttering of outpatient clinics as well as VA medical centers.

In fairness, VA officials who are overseeing Project HERO acknowledge that they are learning from their experiences with HERO, and that, with hindsight, they would have structured the contracts differently. For this, we applaud them. But we do not believe that any wholesale outsourcing of health care services is either warranted or justified by the experiences of HERO.

We agree with a statement by then-Chairman Steve Buyer who stated, on March 29, 2006: "This initiative is not intended to undermine our affiliations, or lead to expanded outsourcing or the replacement of existing VA facilities. It should instead help us learn how to improve some of the contracted care we now provide, and the way we provide it."

If Project HERO accomplishes, this, then it will have been a worthy experiment. But that is all it ought to be: an experiment, not an answer.

Thank you.

Prepared Statement of Sidath Viranga Panangala, Specialist in Veterans Policy, Congressional Research Service, Library of Congress

Introduction

Chairman Michaud, Ranking Member Brown, and distinguished Members of the Subcommittee on Health, my name is Sidath Panangala, from the Congressional Research Service (CRS). I am honored to appear before the Subcommittee today. As requested by the Committee, my testimony will highlight observations on the implementation of Project Healthcare Effectiveness through Resource Optimization (Project HERO). My testimony today is based on the CRS report on Project HERO which has been submitted for the record.

Background

In general, the Department of Veterans Affairs (VA), through the Veterans Health Administration (VHA), provides a majority of medical services to veterans within its health care system. However, in some instances, such as when a clinical service can-

not be provided by a VA medical center, when a veteran is unable to access VA health care facilities due to geographic inaccessibility, or in emergencies when delays could lead to life threatening situations, VHA is authorized by law to send the veteran outside of VA's health care system to seek care.

Policymakers and other stakeholders hold a variety of views regarding the appropriate role of the private-sector in meeting the health care needs of eligible veterans. Some believe that the best course for veterans is to provide all needed care in facilities under the direct jurisdiction of the VA. On the other hand, some see the use of private sector providers as important in assuring veterans' access to a comprehensive slate of services (in particular, to specialty services that are needed infrequently), or in addressing geographic or other access barriers. Those who believe that all needed care should be provided by VA providers in VA-owned facilities are concerned that private sector options for providing care to veterans will lead to a dilution of quality of care in the VA health care system, and could fail to leverage key strengths of the VHA network, such as its system of electronic medical records. Still others hold the view that over the long term, having private sector options could improve the quality of services within the VHA network through competition. Reaching the correct balance between providing care through VA's health care network and through non-VA providers is an issue for policymakers, as well as for the VHA and other stakeholders.

Congress established the Project HERO demonstration to determine if it could provide better management of non-VA provided care. At least two policy questions about Project HERO may be of interest to Congress:

1. Has Project HERO enhanced the existing fee basis care program? [1]
2. Are there findings from the Project HERO that could be applied to standardize the fee basis care program throughout the VA health care system?

Project HERO is primarily an outpatient program. According to VHA data, between January 2008 and September 30, 2009 approximately 51,000 veteran patients have received fee basis care through Project HERO within the four participating Veterans Integrated Service Networks (VISNs) representing approximately 111,000 outpatient visits.

The CRS report submitted for the record describes the current fee basis care program, how Project HERO works compared to the fee basis care program, and quality of care measures used in Project HERO to ensure that veterans receive high quality care even when that care is provided by non-VA providers in the community. Now let me turn to the two broad policy questions that were raised previously.

Has Project HERO enhanced the fee basis care program?

During our visits to three of the four demonstration sites we heard mixed reviews about the pilot program. Some categorized it as a "tool in a toolbox" meaning that Project HERO was one of many options a VA medical facility could use to provide care outside the VA health care system. Some officials categorized Project HERO as a "concierge service" where Humana Veterans Health Care Services (hereafter referred to as HVHS) guides the veterans in scheduling appointments and ensures that clinical information is provided to a network provider and then transferred back to the VA, maintains a credentialed network of providers, and provides claims payment to the health care providers.

The demonstration pilot provides a single point of contact for those veterans who are authorized to receive care outside the VA health care system. Under the demonstration HVHS works with the veteran and the network provider in scheduling the appointment. It also ensures the veteran seeks care from a credentialed provider, as well as facilitates the transfer of medical information, thereby assisting with care coordination. Furthermore, under Project HERO, VA does not have the responsibility for directly paying for care provided outside the system to non-VA providers. However, VA pays for these services through value added fees to HVHS. In FY2009 VA paid approximately $3.3 million in value added fees.

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[1] S.Rept. 111–40 to accompany the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010 (S. 1407) expressed concern about the oversight and scope of Project HERO. See U.S. Congress, Senate Committee on Appropriations, *Military Construction and Veterans Affairs and Related Agencies Appropriation Bill, 2010,* report to accompany S. 1407, 111th Cong., 1st sess., July 7, 2009, p. 53.

Are there lessons to be learned from the pilot program?

The following observations are drawn from our visits to the Project HERO demonstration sites:

1. Establishing a robust network of providers takes time, even when dealing with a health care services provider such as HVHS.

   Most VISNs stated that early on in the pilot HVHS had fair to moderate success building its network of providers within the VISN, and that the short implementation period between the time the contract was awarded in October 2007 and when it became operational in January 2008 was inadequate to establish a robust network of providers. This was especially true in VISNs that had rural or highly rural areas. According to some VISN officials, in some instances this lack of a network of providers has resulted in ongoing challenges in providing timely access to medical care. HVHS has asserted that based on feedback received from the Project HERO Program Management Office, it has worked with VA to resolve most of these issues. For example, HVHS has adapted to the changing clinical needs of each VISN and has attempted to recruit a provider network to meet those clinical needs.

2. Establishing services and pricing, and keeping them up-to-date, is a challenge.

   Some VISNs stated that clinical care services included in the contract were based on prior needs and did not meet the current needs of the network. Some VISNs maintained that some contract pricing is higher than what VA would have paid under the regular fee basis care, and that some services are cost-prohibitive when the value-added fees are applied. However, the Project HERO Program Management Office has noted that 89 percent of Project HERO prices are at or below Medicare rates. Furthermore, the amounts paid by HVHS to providers are less than 7 percent of the regular fee basis care program.[2]

3. Education is key to a successful functioning network.

   Almost all VISNs stated that there has been organizational resistance to change. According to VISN staff, the primary implementation challenge has been in providing training to staff at all levels of the organization, especially educating providers and fee basis care office staff. This has been true even for providers recruited by HVHS, especially when they are required to send clinical information back to the VA.

4. The project has yielded information that could be applied to the existing regular fee basis care program.

   First, without the electronic sharing of medical records between the VA health care system and non-VA providers, there are delays in the transfer of clinical information. In some instances this delay may result in a VA provider not being alerted to the need for immediate follow-up care required based on a diagnosis or laboratory result. This applies to both Project HERO and the regular fee basis care.

   Second, VHA's regular fee basis care program could adopt certain quality metrics that are currently used under Project HERO, such as how far the veteran travels to receive his or her care as well as how long the veteran waits once he or she arrives for an appointment. Lastly, VA could develop a provider network within each VISN that the veteran could be referred to so that the veteran receives care from a provider who has been credentialed similarly to a VA provider. However, prior to implementing this pilot demonstration throughout the VA health care system, it may be useful to conduct an independent evaluation to conclusively measure if Project HERO has been a worthwhile effort.

This concludes my statement. I will be happy to answer any questions the Committee may have.

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[2] Communication received from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, September 29, 2009.

Veterans Health Care: Project HERO Implementation

February 3, 2010

Sidath Viranga Panangala, Specialist in Veterans Policy, Congressional Research Service, 202–707–5700, www.crs.gov

Summary

In general, the Department of Veterans Affairs (VA), through the Veterans Health Administration (VHA), provides a majority of medical services to veterans within its health care system. However, in some instances, such as when a clinical service cannot be provided by a VA medical center, when a veteran is unable to access VA health care facilities due to geographic inaccessibility, or in emergencies when delays could lead to life threatening situations, VHA is authorized by law to send the veteran outside of VA's health care system to seek care. In 2006, the conference report to accompany the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (P.L. 109–114, H.Rept. 109–305) directed the VA to implement a cost effective purchased care management program and to develop at least three pilot programs to encourage collaboration with industry and academia. In response to this requirement, VHA established a demonstration program to enhance the existing fee basis care program that was named Project HERO (Healthcare Effectiveness through Resource Optimization).

In October 2007, VA awarded a contract to Humana Veterans Healthcare Services (HVHS) for medical/surgical, mental health, diagnostic and dialysis services, and the contract became operational in January 2008. Under Project HERO, HVHS maintains a prescreened network of health care providers who meet VA quality standards.

In general, when a patient requires a specific service, and the local VA medical center does not have the specific medical expertise or the technologies to meet that necessity, the local VA medical center authorizes the specific service to be provided under Project HERO. Once the veteran receives care, HVHS is contractually required to return the patient's medical record to the local VA medical center, and HVHS sends the claims data to VA for reimbursement.

VHA's contract and fee basis care expenditures are of interest to Congress for at least two reasons. First, expenditures for contract and fee basis care services are increasing, and second, concerns have been raised about the fee basis care program. Specifically, VA's Office of Inspector General (OIG) has reported that VHA has made a significant number of improper payments for fee basis care as well as in some instances has not properly justified and authorized fee basis care. Given these concerns, and the establishment of the Project HERO demonstration as a means to better manage non-VA provided care, at least two broad policy questions may be of interest to Congress: (1) Has Project HERO enhanced the existing fee basis care program? And (2) Are there lessons to be learned from the Project HERO demonstration that could be applied to standardize the fee basis care program throughout the VA health care system?

This report will first provide a brief overview of the VA health care system, followed by a overview of Project HERO. Second, it will discuss the current fee basis care process as well as the implementation of Project HERO. The report concludes with a discussion of observations on the implementation of Project HERO based on VHA and HVHS perspectives. It should be noted that although dental care services are a component of Project HERO, and are provided through Dental Federal Services (Delta Dental), this report does not discuss dental care services provided under Project HERO. This report will be updated if events warrant.

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Introduction and Overview of the VA Health Care System

The Department of Veterans Affairs (VA), through the Veterans Health Administration (VHA), operates the Nation's largest integrated direct health care delivery system. While Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are also publicly funded, most health care services under these programs are delivered by private providers in private facilities. In contrast, the VA health care system is a truly public health care system in that the Federal Government owns the medical facilities and employs the health care providers.[1]

The VA's health care system is organized into 21 geographically defined Veterans Integrated Services Network (VISNs) (See **Appendix A**.). Although policies and guidelines are developed at VA headquarters, to be applied throughout the system, management authority for basic decision-making and budgetary responsibilities are delegated to the VISNs. VHA's health care delivery network includes 153 hospitals (medical centers), 135 nursing homes, 803 community-based outpatient clinics (CBOCs), 6 independent outpatient clinics, and 271 Readjustment Counseling Centers (Vet Centers), which are supported by more than 242,000 employees.

In general, eligibility for VA health care is based on veteran status, service-connected disabilities or exposures, income, and other factors such as former prisoner of war (POW) status or receipt of the Purple Heart. As required by the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104–262), most veterans are required to enroll in the VA health care system to receive care. Once enrolled, veterans are assigned into one of the eight priority groups based on various criteria. For instance, veterans who are rated 50 percent or more service-connected disabled or who are unemployable due to service-connected disabilities are enrolled in Priority Group 1.[2] According to VA, there are approximately 23.1 million living veterans in the U.S. Of these, approximately 8.3 million (36 percent) were enrolled in the VA health care system, and over 5.0 million unique veteran patients received care from the VA in FY2009.[3]

Generally, veterans have a choice of where they receive their care. While some veterans rely more heavily on care through the VA health care system, the majority of veterans not enrolled in the VA health care system receive care through the private sector which is financed by Medicare, private health insurance, or the military health care system.[4] VHA is a direct health care provider, but it is not generally

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[1] U.S. Congress, House, *Economic Report of the President,* 110th Cong., 2nd sess., February 2008, H. Doc. 110–83 (Washington: GPO, 2008), p. 106.

[2] For a complete discussion of eligibility for VA health care, priority groups, and enrollment, see CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations,* by Sidath Viranga Panangala.

[3] Department of Veterans Affairs, *FY2009 Performance and Accountability Report,* Washington, DC, November 16, 2009, pp. I–16–I17.

[4] Congressional Budget Office, *Quality Initiatives Undertaken by the Veterans Health Administration,* August 2009, p. 5. Veterans who are military retirees have access to TRICARE, the Department of Defense health care plan. For more information, see CRS Report RL33537, *Military*

a third-party payer of care. For veterans who are eligible to receive care through the VA health care system, the decision on whether to receive care from the VA may depend on a variety of factors such as out-of-pocket costs, distance, and waiting times for appointments, among other things.[5]

In general, VHA provides a majority of medical services to enrolled veterans within its health care system. However, in some instances, such as when a clinical service cannot be provided by a VA medical center, and the patient cannot be transferred to another VA medical facility; or when VA cannot recruit a needed clinician; or when a veteran is unable to access VA health care facilities due to geographic inaccessibility; or in emergencies when delays could lead to life threatening situations; VA is authorized to send the veteran outside of its health care system to seek care.[6]

VHA uses two major mechanisms to provide care outside its health care system. These include contracts to purchase care, or non-contracted medical care purchased on a fee for service basis from providers in the community. See the box below for a brief description of these methods.

Methods Used to Provide Care Outside the VA Health Care System

***Contracts to Purchase Care*:** Generally, VA uses two approaches under this method. One is regular commercial contracts that follow Federal Acquisition Regulations, and are awarded on a competitive basis. The second is contracts or agreements with academic affiliates. VA's academic affiliates (schools of medicine, academic medical centers and their associated clinical practices) provide contracted clinical care. Generally, these are non-competitive sharing agreements, and details vary considerably from agreement to agreement. Most cover specialty services such as anesthesiology, cardiology, neurosurgery, ophthalmology, orthopedic surgery, or radiology. Sharing agreements can be based on full-time-equivalent (FTE) employment, or on specific procedures. Compared to fee basis care these contracts involve many patients, and are longer term contracts.

Fee Basis Care: Generally, fee basis care is used to provide outpatient care, and is authorized on a fee-for-service basis per episode of care. VA manages the authorization, claims processing and reimbursement for services acquired from non-VA health care providers. Fee basis care is sometimes referred to as "purchased care."

In 2006, Congress directed VHA to implement a contracting pilot program, that was later named Project Healthcare Effectiveness through Resource Optimization (Project HERO) to better manage the fee basis care program (discussed later in this report).

Policymakers and other stakeholders hold a variety of views regarding the appropriate role of the private sector in meeting the health care needs of eligible veterans. Some believe that the best course for veterans is to provide all needed care in facilities under the direct jurisdiction of the VA. On the other hand, some see the use of private sector providers as important in assuring veterans' access to a comprehensive slate of services (in particular, to specialty services that are needed infrequently), or in addressing geographic or other access barriers. In addition, those who believe that all needed care should be provided by VA providers in VA-owned facilities are concerned that private sector options for providing care to veterans will lead to a dilution of quality of care in the VA health care system, and could fail to leverage key strengths of the VHA network, such as its system of electronic medical records. However, some propose that over the long term, having private sector options could improve the quality of services within the VHA network through competition. Reaching the correct balance between providing care through VA's health care network and through non-VA providers is an issue for policymakers, as well as for the VHA and other stakeholders.

Medical Care: Questions and Answers, by Don J. Jansen, and CRS Report RS22402, *Increases in Tricare Costs: Background and Options for Congress,* by Don J. Jansen.

[5] Congressional Budget Office, *Quality Initiatives Undertaken by the Veterans Health Administration,* August 2009, p. 7.

[6] 38 U.S.C. § 1703 authorizes non-VA inpatient and outpatient medical services on a preauthorized basis by contract or individual authorization; 38 U.S.C. § 1725 authorizes reimbursement for emergency treatment of nonservice-connected conditions in a non-VA facility without prior authorization; 38 U.S.C. § 1728 authorizes reimbursement for emergency treatment of service-connected or related conditions in a non-VA facility without prior authorization.

In addition to these broad concerns, Congress has been interested in specific aspects of VHA's use of private health care services. First, expenditures for contract and fee basis care services are increasing. In FY2008, VHA spent approximately $3.0 billion for contract and fee basis care. By FY2009, that amount had increased by 27 percent to approximately $3.8 billion.[7] These expenditures now comprise an estimated 9 percent of VHA's $41.9 billion total appropriations.[8]

Second, specific concerns have been raised about the fee basis care program. The program is complex, highly decentralized, and lacks a standardized implementation process across the VA health care system. Specifically, VA's Office of Inspector General (OIG) has reported that VHA has made a significant number of improper payments for fee basis care, and in some instances has not properly justified and authorized care.[9]

Congress established the Project HERO demonstration to determine if it could provide better management of non-VA provided care. At least two policy questions about Project HERO may be of interest to Congress:

1. Has Project HERO enhanced the existing fee basis care program?[10]
2. Are there findings from Project HERO that could be applied to standardize the fee basis care program throughout the VA health care system?

To provide some context to the discussion of these questions, this report will first provide an overview of Project HERO. Second, it will discuss the current fee basis care process as well as the implementation of Project HERO. The report concludes with a discussion of observations on the implementation of Project HERO based on VHA and Humana Veterans Healthcare Services Inc. (HVHS) perspectives. This report is based on information received during visits to three of the four Project HERO demonstration sites as well as discussions with officials from HVHS.[11] Although the provision of dental care through Delta Dental Federal Services is part of Project HERO, this report does not discuss this aspect of the program.

Project Healthcare Effectiveness through Resource Optimization (Project HERO)

As stated earlier, in 2006, Congress directed VHA to implement a contracting pilot program, to better manage the fee basis care program. The conference report (H.Rept. 109–305) to accompany the Military Quality of Life and Veterans Affairs Appropriations Act, 2006 (P.L. 109–114) directed the VA to implement a cost effective purchased care management program and to develop at least three objectives-oriented demonstrations (pilot programs) to encourage collaboration with industry and academia. According to the conference report:

> The conferees support expeditious action by the Department to implement care management strategies that have proven valuable in the broader public and private sectors. It is essential that care purchased for enrollees from private sector providers be secured in a cost effective manner, in a way that complements the larger Veterans Health Administration system of care, and preserves an important agency interest, such as sustaining a partnership with university affiliates. In that interest, the VHA shall establish, through competitive award by the end of calendar year 2006, at least three managed care demonstration programs de-

[7] U.S. Congress, Senate Committee on Veterans' Affairs, *A Hearing on VA's Contracts for Health Services,* 111th Cong., 1st sess., September 30, 2009. Answer provided by Gary Baker, Chief Business Officer,Veterans Health Administration, U.S. Department of Veterans Affairs, to a question posed by Senator Daniel Akaka.

[8] CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations,* by Sidath Viranga Panangala.

[9] Department of Veterans Affairs, Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program,* Report No. 08–02901–185, Washington, DC, August 23, 2009, pp. 4–10.

[10] *S.Rept. 111–40* to accompany the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010 (*S. 1407*) expressed concern about the oversight and scope of Project HERO. See U.S. Congress, Senate Committee on Appropriations, *Military Construction and Veterans Affairs and Related Agencies Appropriation Bill, 2010,* report to accompany S. 1407, 111th Cong., 1st sess., July 7, 2009, p. 53.

[11] To better understand Project HERO implementation, on April 22, 2009, August 7, 2009, and August 26, 2009, Congressional Research Service (CRS) staff visited VISNs 8, 16, and 20 respectively. CRS staff did not visit VISN 23. During these meetings, CRS staff received briefings from VHA program staff at the respective VISNs, and held discussions on how the project has been implemented within each VISN. Lastly, on September 17, 2009, CRS staff spoke with officials of Humana Veterans Health Care Services Inc. (HVHS).

signed to satisfy a set of health system objectives related to arranging and managing care.[12]

The VA began developing plans based on this requirement. However, although the conference report language directed VA to implement a managed care demonstration, after meetings with various stakeholders VHA developed a set of objectives that led to a demonstration program to enhance the existing fee basis care program. Its goals were to: [13]

- Provide as much care for veterans within the VHA system as possible;
- When necessary, efficiently refer veterans to high-quality community-based care;
- Improve exchange of information between VA and community providers;
- Increase veteran patient satisfaction;
- Foster high-quality care and patient safety;
- Sustain partnership with university affiliates; and
- Secure an accountable evaluation of demonstration results.

To implement this demonstration VHA selected four Veterans Integrated Services Network (VISNs),[14] based on data that showed that these four networks had the highest expenditures for community-based care relative to the number of veterans enrolled for care. In addition, these areas included some of VHA's largest networks representing 25 percent of VHA's total enrollment.[15] A contract for medical services was awarded on October 1, 2007 to Humana Veterans Healthcare Services Inc. (HVHS).[16] Medical, surgical, mental health, diagnostic, and dialysis services became available through a network of providers recruited by HVHS. The demonstration program became operational on January 1, 2008.

Overview of Fee Basis Care [17]

Services provided in non-VA health care facilities and by non-VA providers fall into two broad categories: contract care and fee basis care. Since Project HERO is a pilot to enhance fee basis care, this part of the report will first provide an overview of the current fee basis care process in the VHA. Under this system VA health care facilities are authorized to pay for health care services acquired from non-VA health care providers. VA manages the authorization, claims processing and reimbursement for services acquired from non-VA health care providers through the fee basis care program.[18]

The fee basis care program is used predominantly to provide outpatient care. Outpatient fee care involves two major phases: (1) pre-authorization of care and (2) claims processing. **Figure 1** provides a generalized depiction of the pre-authorization phase.

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[12] U.S. Congress, Conference Committee, *Making Appropriations for Military Quality of Life Functions, of the Department Of Defense, Military Construction, the Department Of Veterans Affairs, and Related Agencies for The Fiscal Year Ending September 30, 2006, and for Other Purposes,* Report to accompany H.R. 2528, 109th Cong., 1st sess., November 18, 2005, H. Rept. 109–305, pp. 43–44.

[13] Based on briefings provided to CRS Staff by VISN 16 and VISN 20 program staff on August 7, 2009, and August 26, 2009 respectively. For a list of initial objectives see U.S. Congress, House Committee on Veterans' Affairs, *Project Healthcare Effectiveness Through Resource Optimization,* 109th Cong., 2nd sess., March 29, 2006 (Washington: GPO, 2007), p. 66.

[14] The VA's health care system is organized into 21 geographically defined Veterans Integrated Services Network (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision-making and budgetary responsibilities is delegated to the VISNs (see Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA Health Care: Systematizing Quality Improvement and Quality Innovation." *Medical Care.* vol. 38, no. 6 (June 2000), Suppl. 1:I7–16.

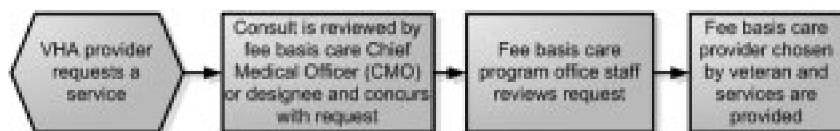
[15] U.S. Congress, House Committee on Veterans' Affairs, *Project Healthcare Effectiveness Through Resource Optimization,* 109th Cong., 2nd sess., March 29, 2006 (Washington: GPO, 2007), p. 16.

[16] The VA contract with HVHS is an indefinite delivery, indefinite quantity (IDIQ) 1-year contract with 4 option years. In general, an IDIQ contract is a type of indefinite delivery contract that provides for an indefinite quantity of supplies or services within stated limits, during a fixed period. The government places orders for individual requirements. Quantity limits may be stated as number of units or as dollar values. Federal Acquisition Regulation (FAR) 16.504.

[17] Major portions of this section were drawn from Department of Veterans Affairs, Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program,* Report No. 08–02901–185, Washington, DC, August 23, 2009, pp. 20–21.

[18] The fee basis care program is sometimes referred to as the purchased care program.

Figure 1. Non-VA Outpatient Fee Basis Care, Pre-Authorization Phase

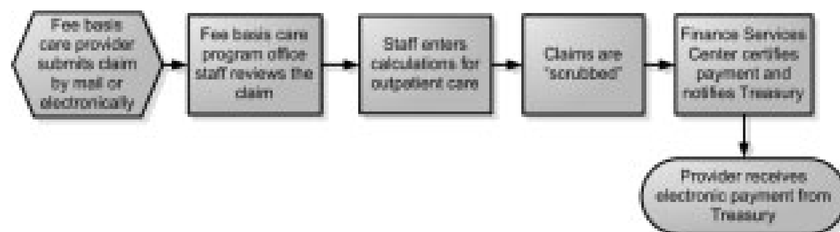


Source: Congressional Research Service graphic based on Department of Veterans Affairs, Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program,* Report No. 08–02901–185, Washington, DC, August 23, 2009, p. 20, and Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System, April 22, 2009.

As seen in **Figure 1** a VA health care provider (generally a clinician) requests a specific health care service or procedure for the veteran and justifies use of non-VA care because of the lack of clinical capacity or capability to provide the service to the veteran. After the initial consult is received by the fee basis care program office at the local VA medical center (VAMC), the Chief Medical Officer (CMO) at the program office, or a designated official, reviews the request and authorizes the care if it is determined to be appropriate. Following this first stage of review, fee basis care program office staff reviews the authorization. They review it to see if the veteran is eligible for the program and whether an appropriate justification has been provided. Once the veteran is notified that the service is authorized, he or she selects a provider and receives services.

The next phase of the fee basis care program is the processing of fee claims. **Figure 2** provides a generalized depiction of receipt and payment of claims.

Figure 2. Receipt and Processing of Fee Claims



Source: Congressional Research Service graphic based on Department of Veterans Affairs, Office of Inspector General, Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, Report No. 08–02901–185, Washington, DC, August 23, 2009, p. 20, and Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System, April 22, 2009.

Notes: Claims "scrubbing" broadly means a process whereby medical claims are validated against a set of established rules such as correct diagnostic codes (International Classification of Diseases, 9th Revision; ICD–9 codes) and procedure codes (such as Current Procedural Terminology (CPT) codes—a list of descriptive terms and identifying codes for reporting medical services and procedures).

Once the veteran receives care from a non-VA provider, the provider sends a claim to the fee basis care program office at the VAMC that authorized the care. The fee basis care program office staff then reviews the claim to ensure that billed services match the services that were authorized. Following this review, staff determines the correct pricing methodology and payment rate based on the type and location of care provided. In the next step the claims are "scrubbed," or validated, to ensure that they are properly coded. After this step staff releases the claim to the Finance Services Center in Austin, Texas to certify fee disbursements to the Department of the Treasury, and the non-VA provider receives an electronic payment.

How Project HERO Works Compared to Fee Basis Care

Under Project HERO, veterans receive primary care at their local VA health care facility, as is the case under the regular fee basis care program. Similarly, if a VA health care provider determines that the specific medical expertise or technology is not readily available at the local facility then the provider requests that the service be obtained from a non-VA provider. The consult request is reviewed by the fee basis care CMO and, if the CMO concurs, the request proceeds to the fee basis care program office. At this point in the process, the fee basis care program office determines whether to send the referral to Project HERO (based on whether the services are provided within a reasonable distance under Project HERO), and if so sends an authorization for care to HVHS.[19]

Generally, authorizations are provided to HVHS for each episode of required care. In contrast to the regular fee basis care program in which the veteran selects his or her own provider, under Project HERO HVHS contacts the veteran by phone to schedule an appointment with an HVHS network provider. During this process appointment details are communicated back to the referring VA health care facility, and the veteran receives a letter with appointment details and instructions. According to HVHS officials, the veteran receives a reminder call prior to the appointment.

HVHS coordinates the transfer of any required pre-visit clinical information from the local VA medical facility to the HVHS network provider. After the veteran is seen by the HVHS network provider, and if additional services are needed, HVHS sends a request back to the referring VAMC for authorization. Under the contract, HVHS is required to return clinical information from the visit back to the referring VA medical facility—typically within 30 days of the appointment. In contrast to regular fee basis care, where clinical information is received directly from the non-VA provider to the referring medical facility, under Project HERO all clinical information is channeled through HVHS. When possible, the information is returned in an electronic format. Otherwise, the information is sent through fax or in hard copy format. Once the clinical information is received, the referring VA medical center reviews it for coordination of care and uploads it into the Computerized Patient Record System (CPRS).[20] Timely return of clinical information to the referring VA medical center is not a requirement under the regular fee-basis care program. Moreover, there is a simplification of claims payment under Project HERO compared to the regular fee basis care process (see **Figure 2**), whereby under Project HERO the network provider submits a claim to HVHS and is paid within about 30 days, and HVHS then submits electronic claims to VA for payment. A general depiction of this process is provided in **Figure 3** and **Figure 4**.

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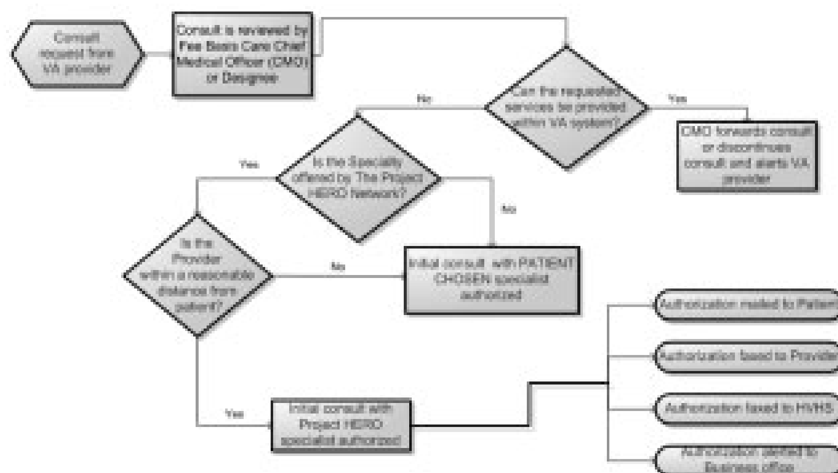
[19] It should be noted that each of the pilot VISNs has inter- and intra-VISN referral policies. For example, if a specific VA medical facility cannot provide the required services, the next step would be to see if another facility within the VISN, and within reasonable distance to the veteran, could provide that specific service or if an academic affiliate or Department of Defense (DoD) sharing agreement could be used to provide that service. If these options are not available then the referring VA medical facility could authorize the use of Project HERO or non-Project HERO fee basis care.

[20] The CPRS is a single integrated system for VA health care providers, and a package within the Veterans Health Information Systems and Technology Architecture (VistA). All aspects of a patient's medical record are integrated, including active problems, allergies, current medications, laboratory results, vital signs, hospitalizations and outpatient clinic history, alerts of abnormal results, among other things. It is used in about 1,300 VHA facilities around the country. CPRS also incorporates data from scheduling, laboratory, radiology, consults and clinic notes into a single integrated patient record.

Figure 3. Authorization Process For Non-VA Care Under Project HERO



Source: Congressional Research Service graphic based on Department of Veterans Affairs, Office of Inspector General, Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, Report No. 08–02901–185, Washington, DC, August 23, 2009, p. 20, and Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System.

Notes: HVHS is Humana Veterans Health Care Services Inc. Also note that this is a generalized depiction and the decision-making process could vary from location to location.

Figure 4. Receipt and Processing of Fee Claims Under Project HERO

Source: Congressional Research Service graphic based on Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System, April 22, 2009.

Project HERO Implementation

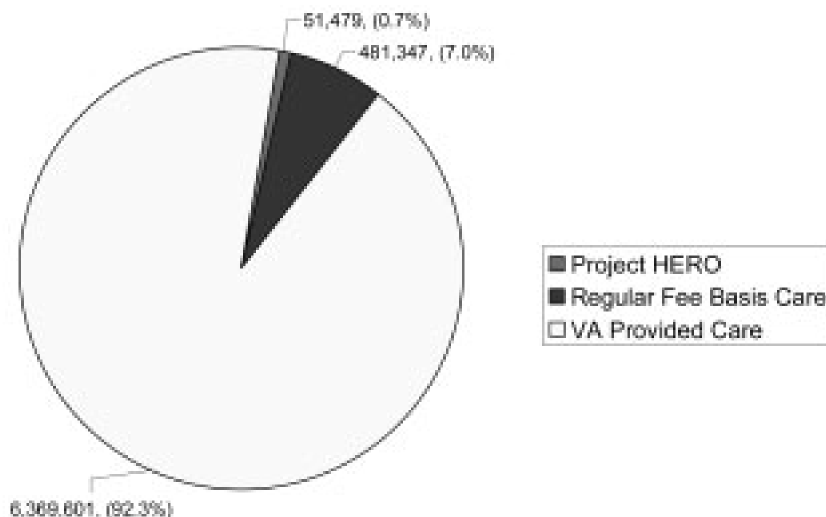
This section provides a brief overview of implementation of the Project HERO demonstration in the four pilot VISNs. This section will discuss utilization of the program compared to regular fee basis care and VA provided care, quality of care under Project HERO, and reimbursement and cost of care under the demonstration program.

Utilization

Project HERO is primarily an outpatient program. According to VHA data, between January 2008 and September 30, 2009 approximately 51,000 veteran patients received care through Project HERO within the four participating VISNs, compared to approximately 481,000 patients who received care through VHA's regular fee basis care program (**Figure 5**). During this same time period there were approximately 111,000 outpatient visits under Project HERO authorizations compared to approximately 1.8 million outpatient visits under regular fee basis care authorizations (**Figure 6**). As seen in the figures below, Project HERO represents a small percentage of all outpatient medical care provided by VHA.

Figure 5. Number and Percent Distribution of Unique Veteran Patients Receiving Outpatient Care

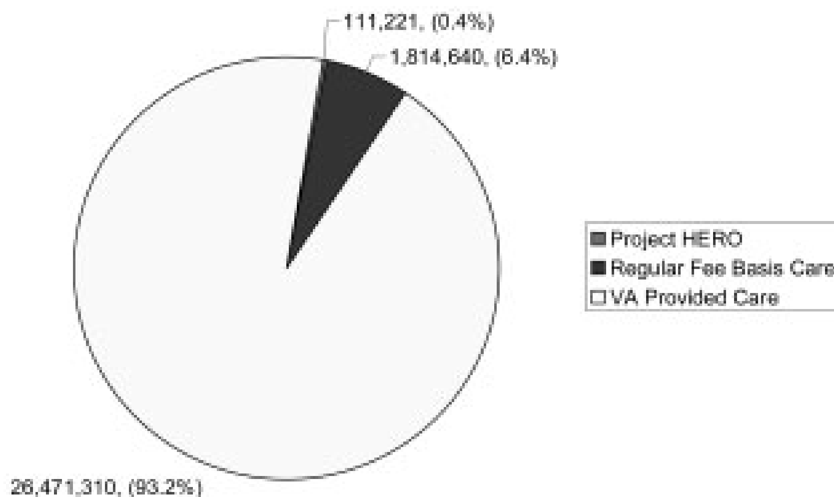
(Total Patients in VISNs 8,16, 20, and 23)



Source: Chart prepared by Congressional Research Service based on data from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office.
Notes: Outpatient care provided from January 1, 2008 thru September 30, 2009.

Figure 6. Number and Percent Distribution of Outpatient Visits

(Total Outpatient Visits in VISNs 8,16, 20, and 23)



Source: Chart prepared by Congressional Research Service based on data from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office.
Notes: Outpatient visits from January 1, 2008 thru September 30, 2009.

Quality of Care

One objective for Project HERO is to ensure that veterans receive high quality care, even when that care is provided by non-VA providers in the community. The Project HERO demonstration includes measures of care along five dimensions: (1) timeliness of access to care, (2) return of clinical information, (3) facility accreditation, (4) patient safety, and (5) complaints.[21] In addition, the demonstration also conducts patient satisfaction surveys. The demonstration project is in its early stages, and the metrics are evolving. However, CRS was able to obtain some preliminary information.

Project HERO is used to provide quality health care when needed health care services are not available. "Not available" means that services are not offered at all, are not available within a reasonable amount of time, or are not available within a reasonable distance, within the VA health care system. Currently, VHA policy has established a goal of scheduling appointments within 30 days of the desired appointment but not more than 4 months beyond the desired appointment date. When a specific appointment date is not requested, VHA policy requires the scheduler to use the next available appointment. Furthermore, VHA policy also requires that all appointment requests, including consult referrals to a specialist, must be acted on by the medical facility within 7 days.[22] The contract requires that HVHS report the following metrics as part of the standard evaluation of access to care: number of times care is provided within 30 days, number of appointments scheduled within 5 days, and number of patients seen within 20 minutes of appointment time. HVHS reports that in August 2009, 93.9 percent of appointments were scheduled within 5 days of receipt of authorization, and that the average time it took to schedule an appointment was 2.1 business days once an authorization was received. HVHS also claims that in the same month 88.2 percent of the referred patients were seen by a HVHS provider within 30 days.[23]

Under Project HERO, VHA did not establish drive time or distance requirements in the contract with HVHS. However, due to the need for such a standard, a business process has been mutually agreed upon by VHA and HVHS. HVHS notifies the referring VA medical center if the care provider is more than 50 miles from the veteran's home address. The referring VA medical center can determine if it is a reasonable distance based on where the veteran lives. If the VA medical center staff believes they can obtain care closer to the veteran, they can cancel the HVHS authorization and issue a regular fee basis care authorization.

With respect to the return of clinical information, under the Project HERO demonstration HVHS is required to provide clinical data generated as result of a routine referral for authorized care to the referring medical facility within 30 days of the appointment date, although this is not a requirement under the regular fee basis care program. Early reports from the Project HERO Program Management Office indicated that HVHS did not meet the 100 percent standard, and showed a downward trend in this measure, meaning that the percentage of records returned within 30 days was declining.[24] In September 2009, HVHS claimed that it was working on process improvements and on educating noncompliant providers. HVHS reported in August that average business days to return clinical information is 14.3 days.[25]

Accreditation of facilities and credentialing of providers are seen as proxy measures to evaluate quality of clinical care provided. Generally, under the regular fee basis care program, once a veteran is authorized to receive care outside the VA health care system, the veteran is free to choose a provider within the community. Therefore, although the provider may be licensed to practice medicine within the State, he or she is not necessarily credentialed in a manner similar to the credentialing process that VHA uses to credential its own health care providers.[26] However, under Project HERO requirements, HVHS has stated that it recruits credentialed providers using the same guidelines that VHA uses for its providers.

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[21] Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, *Project HERO Demonstration Evaluation Monthly Report,* July 2009.

[22] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health and Subcommittee on Oversight and Investigations, *Outpatient Waiting Times,* 110th Cong., 1st sess., December 12, 2007. p. 35.

[23] Humana Veterans Health Care Services briefing, September 17, 2009.

[24] Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, *Project HERO Demonstration Evaluation Monthly Report,* July 2009.

[25] Humana Veterans Health Care Services briefing, September 17, 2009.

[26] VHA policy requires that all VHA health care professionals who are permitted by law and the facility to provide patient care services independently must be credentialed and privileged. Credentialing is done to ensure that a provider has the required education, training, experience, physical and mental health, and skill to fulfill the requirements of the position and to support the requested clinical privileges (see VHA HANDBOOK 1100.19, November 14, 2008).

Credentialing includes verification of appropriate education, certificates, licensing, criminal record, registrations and insurance. According to HVHS it only sends veterans to providers who meet VA credentialing requirements.[27] In addition, the Project HERO HVHS network of providers is required to practice at Joint Commission accredited facilities. Currently all facilities providing inpatient care within the contractor network are accredited by one of the following organizations: The Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), The Intersocietal Commission for the Accreditation of Vascular Laboratories (ICVAL), or the American Osteopathic Association (AOA). According to the VA, the Project HERO Program Management Office audits HVHS for provider credentialing and facility accreditation, and to date, the VA has stated that the audit results have shown that HVHS providers are compliant with credentialing requirements.

According to the VHA National Patient Improvement Handbook, patient safety is ensuring freedom from accidental or inadvertent injury during health care processes.[28] Under Project HERO patient safety incidents must be reported within one business day to the referring VA medical facility, and these violations are required to be investigated and resolved by VHA and HVHS. In its July 2009 monthly report, the Project HERO Program Management Office did not report any patient safety violations.

With respect to complaints, a majority of complaints in the July 2009 report were related to the authorization process. For example: "one veteran was sent to a provider who could not perform the procedure needed," "another veteran had an appointment rescheduled and his medical records were not requested," and "another veteran went to an appointment and was told that the appointment was not scheduled for him."[29]

As part of Project HERO, HVHS conducts surveys of patients to measure patient satisfaction, and these are reported to the Project HERO Program Management Office. In its July 2009 report (representing averaged data from October 2008–March 2009), the Project HERO Program Management Office indicated that over 75 percent of patients were very or completely satisfied with their visit and 80 percent rated the overall quality of the visit as very good or excellent. However, only 52 percent were satisfied with their appointment wait times.[30]

Costs and Reimbursements

Project HERO prices for medical care are a negotiated percentage of U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) rates based on the local market rates where the services are provided. In contrast, under the regular fee basis care, with the exception of physician services, dialysis and laboratory testing, VHA does not have authority to pay at CMS rates. VHA pays for regular fee basis outpatient care based on the lesser of the amount billed by the provider or the amount calculated using a formula developed by CMS' participating physician fee schedule for the period in which the service is provided. If there is no calculated amount under the CMS' participating physician fee schedule, reimbursements are based on the lesser of the actual amount billed or the amount calculated using the VA's 75th percentile methodology or the usual and customary rate.[31] Under Project HERO, VHA pays HVHS a value added fee that ranges from $30.75 to $48.09 per claim, and these amounts vary by VISN and type of service (See **Table 1**.).

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[27] Humana Veterans Health Care Services briefing September 17, 2009.

[28] Department of Veterans Affairs, Veterans Health Administration, VHA HANDBOOK 1050.01, May 23, 2008.

[29] Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, *Project HERO Demonstration Evaluation Monthly Report,* July 2009.

[30] Ibid, pp. 9–11.

[31] 38 CFR § 17.56. Reimbursement under the 75th percentile methodology is determined for each VA medical facility by ranking all treatment occurrences of a medical procedure (with a minimum of eight) under the corresponding Current Procedural Terminology (CPT®) codes during the previous fiscal year with charges ranked from the highest to the lowest rate billed and the charge falling at the 75th percentile as the maximum amount to be paid. If there are fewer than eight treatment occurrences for a procedure during the previous fiscal year then VA pays based on the provider's usual or customary charges.

Table 1. Value Added Fee Amounts, FY2009

	VISN 8	VISN 16	VISN 20	VISN 23
Medical or Surgical Care Services	$30.75	$30.75	$39.50	$39.24
Mental Health Care Services	$36.89	$36.89	$45.74	$48.09
Diagnostic Services	$30.75	$30.75	$39.50	$39.24
Dialysis	$30.75	$30.75	$39.50	$39.24

Source: Humana Veterans Healthcare Services.

The value added fee supports provision of such services as: coordinating appointments for veterans; returning clinical information (for example medical records) to VHA; processing provider invoices for reimbursement to providers; and monitoring and reporting access to care, appointment timeliness and patient safety. As seen in **Table 2**, in FY2008 VHA paid approximately $69,000, and for FY2009 it paid HVHS approximately $3.3 million in value added fees.

Table 2. Project HERO Payments Including Value Added Fees

	Project HERO Payments for Health Care, Excluding Value-Added Fees [a]	Project HERO Value Added Fees [b]	Total Project HERO Payments	Value Added Fees as a % of Project HERO Payments	VISN Budgets [c]	Total Project HERO Payments as % of VISN Budgets
FY2008	$5,223,422	$69,089	$5,292,511	1.30%	$8,973,617,617	0.06%
FY2009	$38,669,257	$3,305,067	$41,974,324	7.87%	$9,685,045,154	0.43%

Source: Department of Veterans Affairs, Veterans Health Administration, Chief Business Office.

Notes:

a. Project HERO Payments are VHA payments to Humana Veterans Health Care Services Inc. excluding any value added fees (VISNs 8, 16, 20, and 23), and do not include dental care payments to Delta Dental. Payments for FY2008 are from January 2008 through September 2008, and payments for FY2009 are from October 1, 2008 through September 30, 2009.

b. Value added fees are payments made by VHA to Humana Veterans Health Care Services Inc (HVHS) for services such as coordinating appointments for veterans; returning clinical information to VHA on a timely basis; processing provider invoices for quick reimbursement to providers; and monitoring and reporting access to care, appointment, timeliness and patient safety. Data are based on HVHS reporting of value added fees.

c. FY2008 VISN budgets (total VISN budgets for 8, 16, 20, and 23) are obligations as of September 30, 2008 and FY2009 VISN budgets are as of July 31, 2009.

Discussion

Stakeholders have voiced various concerns about care provided outside the VA health care system, and these concerns have been voiced regarding both contract care and fee basis care. Some Veterans Service Organizations (VSO) are concerned that a mixture of government providers and private providers could grow over time and place at risk the VA health care system as a whole.[32] Unions are concerned that care provided by non-VA providers would eventually lead to “outsourcing of functions that have traditionally been performed in-house.”[33]

Congress has expressed concern with the growth of non-VA provided care, and whether VHA is prudently using taxpayer dollars to purchase care for veterans. Congress has also expressed concern about whether VHA can ensure timely access to quality care when that care is provided by outside providers.[34] The Project HERO demonstration is characterized by the VA as an effort to address these concerns and in the early stage of its implementation is perceived to have achieved mixed results.

[32] U.S. Congress, House Committee on Veterans’ Affairs, *Project Healthcare Effectiveness Through Resource Optimization,* 109th Cong., 2nd sess., March 29, 2006 (Washington: GPO, 2007), p. 76.

[33] U.S. Congress, Senate Committee on Veterans’ Affairs, *A Hearing on VA’s Contracts for Health Services,* 111th Cong., 1st sess., September 30, 2009. Testimony by Mary A. Curtis, Psychiatric Clinical Nurse Specialist and Clinical Application Coordinator Boise VA Medical Center Boise, Idaho, on Behalf of American Federation of Government Employees, AFL–CIO.

[34] U.S. Congress, Senate Committee on Veterans’ Affairs, *A Hearing on VA’s Contracts for Health Services,* 111th Cong., 1st sess., September 30, 2009.

The next part of this report addresses the two questions posed at the beginning of this report.

Has Project HERO enhanced the fee basis care program?

During visits to three of the four demonstration sites CRS heard mixed reviews about the pilot program. Some categorized it as a "tool in a toolbox" meaning that Project HERO was one of many options a VA medical facility could use to provide care outside the VA health care system (other options include care through medical school affiliates or through existing contracts with local providers, among others). Some officials categorized Project HERO as a "concierge service" where HVHS guides the veterans in scheduling appointments and ensuring that clinical information is provided to a network provider and then transferred back to the VA, as well as maintaining a credentialed network of providers, and claims payment to providers.

The current Project HERO demonstration could be categorized as an enhancement of the regular fee basis care program. The demonstration pilot provides a single point of contact for those veterans who are authorized to receive care outside the VA health care system. Under the demonstration HVHS works with the veterans and the HVHS network provider in scheduling the appointment. It also allows the veteran to seek care from a credentialed provider, as well as facilitates the transfer of medical information, thereby assisting with care coordination. Furthermore, under Project HERO, VA does not have the responsibility for paying for care provided outside the system directly to non-VA providers. However, VA pays for these services through value added fees to HVHS.

Are there lessons to be learned from the pilot program?

1. Establishing a robust network of providers takes time, even when dealing with an established health care services provider.

Most VISNs stated that early on in the pilot HVHS had fair to moderate success building its network of providers within the VISN, and that the short implementation period between the time the contract was awarded in October 2007 to when it became operational in January 2008, was inadequate to establish a robust network of providers. This was especially true in VISNs that had rural or highly rural areas. According to some VISN officials, in some instances this lack of a network of providers has resulted in ongoing challenges in providing timely access to medical care. HVHS has asserted that based on feedback received from the Project HERO Program Management Office, it has worked with VA to resolve most of these issues. For example, HVHS has adapted to the changing clinical needs of each VISN and has attempted to recruit a provider network to meet those clinical needs.

2. Establishing services and pricing, and keeping them up-to-date, is a challenge.

Some VISNs stated that clinical care services included in the contract were based on prior needs and did not meet the current needs of the network. Some VISNs also raised the issue that some contract pricing is higher than what VA would have paid under the regular fee basis care, and that some services are cost-prohibitive when the value-added fees are applied. However, the Project HERO Program Management Office has noted that 89 percent of Project HERO prices are at or below CMS rates, and that amounts paid to providers are less than 7 percent of the regular fee basis care program.[35]

3. Education is key to a successful functioning network.

Almost all VISNs stated that there has been organizational resistance to change. According to VISN staff, the primary implementation challenge has been providing training to staff at all levels of the organization, especially educating providers and fee basis care office staff. This has been true even for providers recruited by HVHS, especially when they are required to send clinical information back to the VA.

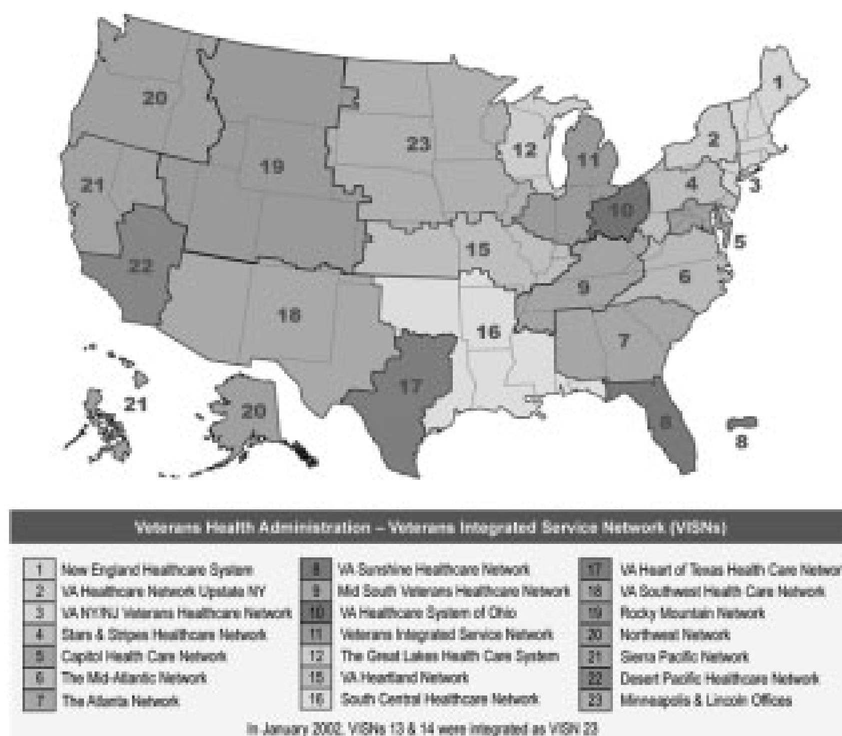
4. The project has yielded information that could be applied to the existing regular fee basis care program.

First, without the electronic sharing of medical records between the VA health care system and non-VA providers, there are delays in the transfer of clinical information. In some instances this delay may result in a VA provider not being alerted to the need for immediate follow-up care required based on a diagnosis or laboratory result. Second, VHA's regular fee basis care program could adopt certain quality metrics that are currently used under Project HERO, such as how far the veteran

[35] Communication received from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office, September 29, 2009.

travels to receive his or her care as well as how long the veteran waits once he or she arrives for an appointment. Lastly, VA could develop a provider network within each VISN that the veteran could be referred to so that the veteran receives care from provider who has been credentialed similarly to a VA provider. However, prior to implementing this pilot demonstration throughout the VA health care system, it may be useful to conduct an independent evaluation to conclusively measure if Project HERO has been a worthwhile effort.

Appendix A. Veterans Integrated Services Network (VISNs)



Source: Department of Veterans Affairs, adapted by Congressional Research Service.

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Prepared Statement of Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to discuss our findings related to how the Veterans Health Administration (VHA) purchases health care services for veterans from non-VA providers. I am accompanied by Gary Abe, Director, Seattle Office for Audits and Evaluations, Office of Inspector General (OIG). As health care costs continue to increase in VA and elsewhere, ensuring that VA has strong controls over purchased care activities is a crit-

ical aspect of providing the care veterans need. To address this concern, over the past 2 years, we have issued two reports—*Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements* and *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program.* In addition, we are currently reviewing the Inpatient Fee Care Program and FSS contracts for professional and allied health services; we plan to issue audit reports on these issues later in FY 2010. To date, our audits of purchased care have identified significant weaknesses and inefficiencies. Specifically, we have found that VHA has not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly billed.

BACKGROUND

When we initiated our audits in fiscal year (FY) 2008, VHA's medical care budget totaled approximately $39 billion. In FY 2009, the medical care budget increased to about $44 billion. We estimate that of this amount, VHA spent about $5.3 billion (12 percent) to purchase health care services from non-VA entities such as other government agencies; affiliated universities; community hospitals; nursing homes; and individual providers. VHA uses various mechanisms to purchase health care services, including sharing agreements with affiliated universities and the Department of Defense, Federal Supply Schedule (FSS) contracts, the Non-VA Fee Care Program, Project HERO, and the Foreign Medical Program. According to VHA managers, the authority to purchase services from non-VA sources helps to improve veterans' access to needed health care services, in particular specialty care that may not be available at VA medical centers (VAMCs) or that VAMCs have a difficult time recruiting and retaining specialists to provide.

Audit of Noncompetitive Clinical Sharing Agreements

Title 38 of the United States Code (USC), Section 8153, authorizes VA to enter into noncompetitive sharing agreements with affiliated institutions and entities associated with these institutions. In practice, many sharing agreements are ones in which VA buys specialized clinical services, such as anesthesiologists or cardiac surgeons, from affiliated medical schools, university hospitals, clinical departments, and associated medical practice groups. These medical specialists provide services onsite in VAMC operating rooms, clinics, and inpatient medical wards. When we initiated the audit in FY 2008, VHA reported having about 670 noncompetitive clinical sharing agreements valued at $575 million.

Performance monitoring controls over noncompetitive clinical sharing agreements were not effective; as a result, VHA lacked reasonable assurance it received the services it paid for. Our review of 58 high cost surgical and anesthesiology sharing agreements at 8 randomly selected VAMCs found that controls over contract performance monitoring for services provided onsite at the VAMCs under all 58 agreements needed strengthening.

- For 34 full-time equivalent employee (FTE) based agreements, contracting officers' technical representatives (COTRs) did not monitor the actual amount of time contractors worked or whether the hours worked met the FTE levels required by the agreements. For example, one VAMC paid for 2.0 FTE vascular surgeons, but our review determined that the time provided by contract vascular surgeons equated to less than 1.2 FTE. The COTR acknowledged that while she reviewed the surgeons' workload, she did not monitor their time. As a result, the VAMC overpaid $333,030 for time the vascular surgeons were not at the VAMC.
- For 24 procedure-based agreements, COTRs did not always ensure that all of the services were actually received or needed and that contractors correctly calculated Medicare-based charges. For example, at one VAMC, a contractor overcharged $1,022 for 31 procedures because it billed rates that were higher than the Medicare rates applicable to the geographical area. The COTR did not review the charges or verify the accuracy of the rates prior to certifying payments. If left unmonitored, even routine procedure billings with low value financial errors can build over time into significant overpayments.

Because of these weaknesses in performance monitoring, VAMCs overpaid contractors on 30 (52 percent) of the 58 agreements. Strengthening controls over performance monitoring would save VHA about $9.5 million annually or $47.4 million over 5 years.

Specifically, we identified three areas that required strengthening:

- **Specify Performance Requirements.** The sharing agreements did not specifically and accurately state performance requirements for the contractors.

Clear performance requirements tell the COTRs what services will be provided, who will provide the services, and the rates to be charged.

- **Improve Oversight of COTRs.** Contracting officers and VHA officials did not adequately oversee COTR activities. Contracting officers did not provide the COTRs clear guidance about their monitoring responsibilities, nor did they implement procedures to routinely review the COTRs' activities to ensure they were effective.
- **Provide Specialized Training to COTRs.** COTRs did not have sufficient training to monitor clinical sharing agreements. Although most of the COTRs had general contract monitoring training, they had not received any specialized training on how to establish effective monitoring systems for FTE-based and procedure-based clinical sharing agreements. For example, many of the COTRs were unfamiliar with Medicare-based charges commonly used in procedure-based agreements.

We made seven recommendations to strengthen controls over sharing agreement performance monitoring. The Under Secretary for Health agreed with our findings and recommendations and provided acceptable implementation plans to address the recommendations. VHA is still in the process of implementing the recommendations.

Audit of Non-VA Outpatient Fee Care Program

Title 38 of the USC, Sections 1703, 1725, and 1728, permits VA to purchase health care services on a fee-for-service or contract basis when services are unavailable at VA facilities, when VAMCs cannot provide services economically due to geographical inaccessibility, or in emergencies when delays may be hazardous to a veteran's life or health. The Non-VA Fee Care Program accounts for the bulk of VHA's purchased care spending with estimated FY 2008 expenditures exceeding $2.6 billion; it is also VA's fastest growing purchased care activity. For example, outpatient fee costs have more than doubled during the 4-year period FY 2005–2008, from $740 million to $1.6 billion, and in FY 2009, outpatient fee costs were just under $2 billion.

Our recently issued audit report focused on the Outpatient Fee Care Program. In FY 2008, 137 VAMCs processed an estimated 3.2 million outpatient fee claims. These claims were for a wide range of diagnostic and therapeutic services including visits to primary care physicians, x-rays and diagnostic imaging procedures, chemotherapy and radiation therapy, dialysis, physical therapy, and outpatient surgical procedures. Based on our review of a statistical sample of 800 claims, we concluded that VHA had not established adequate management controls and oversight procedures to ensure that claims for outpatient fee services were accurately paid, justifications for services were adequately documented, and services were properly preauthorized.

- VAMCs improperly paid 37 percent of outpatient fee claims by making duplicate payments, paying incorrect rates, and making other less frequent payment errors, such as paying for the wrong quantity of services. As a result, we estimated that in FY 2008, VAMCs overpaid $225 million and underpaid $52 million to fee providers, or about $1.13 billion in overpayments and $260 million in underpayments over 5 years.
- For 80 percent of outpatient fee claims we reviewed VAMCs did not adequately document justifications for use of outpatient fee care or properly pre-authorize services as required by VHA policy, thereby increasing the risk of additional improper payments. However, our audit did not assess or question the clinical necessity of services.

We concluded that the improper payments, justifications, and authorizations occurred because VHA had not established an adequate organizational structure to support and control the complex, highly decentralized, and rapidly growing fee program. We identified three specific areas that required strengthening:

- **Develop Comprehensive Fee Policies and Procedures.** VHA does not have a centralized source of comprehensive, clearly written policies and procedures for the Fee Program. Instead, fee supervisors and staff must rely on an assortment of resources including the Code of Federal Regulations, outdated VA policy manuals, and other procedure guides, training materials, or informal guidance.
- **Identify Core Competencies and Require Training for Fee Staff.** Because the Fee Program is very complex and requires significant judgment by fee staff to ensure correct payments, processing fee claims requires specialized knowledge and skills, such as understanding medical records, insurance billing con-

cepts, and medical procedure coding. However, VHA does not require fee staff or their supervisors to attend initial or refresher training.

- **Establish Clear Oversight Responsibilities and Procedures.** Strong oversight of the Fee Program should include procedures and performance metrics for assessing compliance with program requirements, conducting risk assessments, assessing program controls, and monitoring accuracy and quality of claims processing. However, no one from VHA's Chief Business Office, National Fee Program Office, Veterans Integrated Services Network, or Compliance and Business Integrity Office is routinely performing oversight activities of the Fee Program.

We made eight recommendations to strengthen controls over the Outpatient Fee Care Program. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable implementation plans to address the recommendations. In his response, he also stated that information technology (IT) gaps were "key drivers in the erroneous payments" identified by our audit. He pointed out that fee staff manually process many claims and that few upgrades have been made to the VistA Fee system in the past 10 years. As part of our ongoing audit of inpatient fee care, we are examining the Under Secretary's concern about IT gaps and assessing the impact of IT systems on claims processing accuracy and efficiency.

CONCLUSION

While purchasing health care services from non-VA providers may afford VHA flexibility in terms of expanded access to care and services that are not readily available at VAMCs, it also poses a significant risk to VA when adequate controls are not in place. With non-VA health care costs of about $4.8 billion in FY 2008 and future costs expected to increase, VHA needs to strengthen performance monitoring over clinical sharing agreements and improve controls over claims processing and the justification and authorization of fee services. Without adequate controls, VHA lacks reasonable assurance that it is receiving the services it pays for, that the services are needed, or that the prices paid for services are correct. Furthermore, it does not have the information it needs to assess whether this approach for delivering health care to veterans is efficient and economical.

Mr. Chairman, thank you for the opportunity to discuss these important issues. We would be pleased to answer any questions that you or other Members of the Subcommittee may have.

Prepared Statement of Tim S. McClain, President and Chief Executive Officer, Humana Veterans Healthcare Services, Inc.

INTRODUCTION

Chairman Michaud, Ranking Member Brown, and distinguished Committee Members, thank you for the opportunity to address the Committee on **Project HERO** (Health Care Effectiveness through Resource Optimization) and the supporting role Humana Veterans Healthcare Services plays in the delivery of excellent health care to our Nation's veterans.

On behalf of the dedicated men and women of Humana Veterans, I appreciate the opportunity to provide information to the Committee on the three hallmarks of Project HERO: (1) **Quality** health care solutions for veterans, including personalized services tailored for each veteran; (2) timely **Access** to care; and, (3) **Cost** effective care.

I am President and CEO of Humana Veterans, the company responsible for providing health care services for the Veterans Affairs Project HERO demonstration and welcome this opportunity to discuss the objectives, successes and efficiencies of Project HERO that make it a clear benefit to the Department, and most importantly, to the veterans relying on VA for excellent medical care.

OVERVIEW OF PROJECT HERO CONTRACT

Project HERO is a demonstration project (pilot) currently implemented in four Veteran Integrated Service Networks: VISN 8, 16, 20 and 23. The project is congressionally inspired and has developed into a partnership between the U.S. Department of Veterans Affairs, Veterans Health Administration (VHA) and Humana Veterans.

Humana Veterans was awarded the contract for medical/surgical, mental health, diagnostics and dialysis for Project HERO on October 1, 2007. Delta Dental Federal Services (Delta Dental) was awarded the contract for dental services. My testimony

today addresses only the partnership between the VA and Humana Veterans and does not intend to address the contract awarded to Delta Dental.

The purpose of the project is to determine how a personalized services approach to care provided outside the VA (traditionally termed "fee-based care") can improve and complement the timely access and quality of care, preserve the fiscal integrity of VA health care expenditures, while maintaining high customer satisfaction. We at Humana Veterans believe Project HERO has succeeded in all of these areas.

As displayed on the map in Exhibit A (attached), HERO is currently a four-VISN demonstration including the Sunshine Healthcare Network (VISN 8); South Central Healthcare Network (VISN 16); Northwest Healthcare Network (VISN 20); and the Midwest Healthcare Network (VISN 23). We understand VA selected these four VISNs for Project HERO based on their considerable fee-based populations and the significant amount of health care funds expended on veterans care through the VA's regular fee-basis program.

CONTRACT STATUS

Humana Veterans contract, which was awarded October 2007, consists of a base contract with 4 option years. Performance under the contract commenced on January 1, 2008 and VA has exercised an option extending the term of the current contract through September 30, 2010.

OBJECTIVES

The Project HERO solicitation, sent out to bid in late December 2006, clearly identified a number of overall objectives for the demonstration. These objectives remain steadfast today and are objectives Humana Veterans strives to attain as we collaborate with VA to improve the level of care provided to our Nation's veterans outside VA facilities. The objectives outlined in the solicitation included:

- **Cost**—providing cost-effective, consistent, and competitive pricing.
- **Quality of Care**—ensuring the quality of community care provided.
- **Patient Satisfaction**—achieving high patient satisfaction.
- **Clinical Information**—improving the exchange of patient care information between community providers and the VA.
- **Patient Safety**—fostering high quality care and patient safety.
- **Transparency**—improving care coordination so all care, including care provided outside of the VA, is perceived by the patient as VA care.
- **Clinical Coordination**—ensuring efficiency in the VA referral process and timely appointments for patients.
- **Coverage**—providing health services to veterans where and when the VA does not have capacity or capability to deliver services internally.

It is important to highlight that we believe Humana Veterans has met or exceeded each of the contract objectives to date. The result is better health care services to veterans. While these objectives are crucial in providing services for the men and women who have honorably served our Nation, there is a more implicit goal of Project HERO. That goal is to combine all of these elements and create a standardized method of providing fee-basis care to ensure eligible veterans gain timely access to care, in a manner that is cost-effective to the VA, and most importantly, preserves the level of service veterans have come to rely on *inside* the VA. After nearly 18 months of working diligently with our partners at VA, we are delivering on these objectives.

PROJECT HERO MODEL

Humana Veterans, in collaboration with VA, coordinates quality, timely access to health care services through Project HERO. VA refers patients to community health care providers when there is a need for specialty care or other treatment that is not readily available at the VA facility. This is accomplished through a model developed by Humana Veterans, in partnership with VA.

The Project HERO Model includes a personalized service process for veterans and is outlined below:

a. First, the veteran receives authorization for care from the VA. Before issuing an authorization, the VA determines if the specialty or other care is available at a VA facility, if the veteran lives a significant distance from that facility, or makes a determination based on other medical reasons. The VA then determines whether to send the authorization directly to the veteran, send it to the

Project HERO office at Humana Veterans, or refer the veteran directly to a community provider.

b. When an authorization is sent to Project HERO, the veteran receives personal assistance and specialized services. Initial contact with the veteran is made by a Customer Care Representative (CCR) at Humana Veterans. This appointment specialist provides an explanation of the HERO process and determines when the veteran is available for the medical appointment. In terms of making the encounter more veteran-friendly, we developed our personalized services approach for three reasons: (a) to ensure the veteran is comfortable with what the medical appointment will entail; (b) the veteran understands where the civilian provider is located; and, (c) ensure maximum reliability in terms of the appointment date established between the veteran and HERO contract provider.
c. The CCR then conducts a three-way conference call with the veteran and a Humana Veterans network provider's office. This call occurs within 5 days of receiving the authorization form from the VA. As part of the Humana Veterans network agreement, network providers must schedule appointments within 30 days of the conference call. In any event, the veteran must agree to the scheduled date.
d. The veteran receives a letter confirming the provider's name, address, telephone number, date and time of appointment, including how to obtain directions to the provider's office and Humana Veterans customer service number should questions or problems arise. The referring VA facility is also informed of the appointment details.
e. The veteran goes to the scheduled appointment. An agreement with our network providers limits the veteran's wait time to no longer than 20 minutes when they are in the office for their scheduled appointment. If a copy of the veteran's medical records is required, we contact the VA to inform them of the provider's request.
f. After the appointment, we actively track the provider's written consult report and ensure it is returned to the VA for inclusion in the veteran's electronic health record. The average time for a consult report to be returned to VA is 16 days.
g. If the provider recommends the veteran have additional tests, procedures or services, Humana Veterans communicates the recommendation to the VA for review and action. When providers submit their claims to us, we pay the provider directly within 30 days of receipt of the claim. We then submit the claim for services under the contract and VA pays Humana Veterans.
h. Finally, we are committed to a seamless "hand-off" of the veteran back into the VA system and their primary care providers. This personalized approach is beneficial to the veteran. The return of clinical information in a timely manner ensures quality and continuity of care.

CONTRACT PERFORMANCE REQUIREMENTS

The following are the specific performance metrics enumerated in the Project HERO contract:

Access. Appointments with specialists and routine diagnostics are scheduled for veterans within 30 days of receipt of the referral by the provider and the provider will see veterans within 20 minutes of their scheduled appointment.

Accreditation. Unless a waiver exists, all facilities providing inpatient care must be accredited by the Joint Commission (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Intersocietal Commission on the Accreditation of Vascular Laboratories (ICAVL), or the American Osteopathic Association (AOA). Humana Veterans must provide proof of accreditation to the VA for providers.

Clinical Information. All routine clinical information and test results must be returned within 30 days from the day of care. For inpatient care, clinical information must be returned within 30 days of the veteran's discharge.

Credentialing. Humana Veterans provides written certification to the VA validating network providers are credentialed, including physician assistants, registered professional nurses, nurse practitioners, and other personnel in the network providing health care services to veterans. The VA conducts random inspections of our credentialing files guaranteeing this compliance.

Patient Safety. Humana Veterans reports all patient safety reports/incidents to the VA and Contracting Officer Technical Representative (COTR). All safety events are investigated, confirmed, and resolved and the VA informed of the progress in resolving safety events.

Patient Satisfaction. Humana Veterans designated a Patient Advocate with the responsibility of receiving veteran grievances. We submit all patient complaints regarding quality of care to the VISN Patient Advocate and COTR. We developed materials outlining the grievance process and assist veterans with complaints.

Reporting Requirements. Humana Veterans submits a monthly report to the VA including metrics on contract performance standards plus a variety of other metrics. We maintain a data repository (Data Mart) and provide unlimited access to the VA. Anyone in the Project Management Office (PMO) or Fee Office at the VAMC level has access to the data and may pull reports on the metrics, after access is granted by the COTR.

MISCONCEPTIONS

Mr. Chairman, now that I have established the rationale for the development of the demonstration, at this point I feel it is also important to address some serious, ongoing misconceptions regarding Project HERO. I firmly believe the perpetuation of these misconceptions is a disservice to veterans enjoying the many benefits of Project HERO, to VA as it executes this demonstration project, and to Humana Veterans as we continue serving veterans through our HERO Model. I will address two misconceptions that emerged early on in the demonstration project and continue to linger to some degree today. It is a "Myth vs. Fact" phenomenon.

Myth Number 1

Project HERO seeks to undermine the care currently provided inside VA facilities, leading to greater levels of care in the community, and ultimately diminishing the VA health care delivery system as a national treasure for veterans.

Fact

VA and Humana Veterans are clearly in agreement that is false. I want to explain why this claim is erroneous. As you know, traditional VA fee-basis care, and care now provided through Project HERO, are authorized and provided only when the requisite capacity inside VA does not support the timely access to care or a specialty is not available in VA. *Simply translated, this means the VA retains ultimate control over who enters the community for care, including which patients are referred to HERO for personalized services.* We understand the statutory mandate that the VA must provide care inside its' proverbial four walls whenever possible. HERO, and the processes developed under it, was created to serve as an effective complement to the high quality care VA provides internally, not an initiative to supplant it.

Having said that, we are also aware the VA spends more than three billion dollars per year nationally on care outside VA facilities. We recognize that the demand for services is often times beyond the control of the VA—in such instances as veterans residing in rural areas or the lack of specialty providers available to the VA in a given geographic area. HERO could serve as an effective backstop at times when the VA's internal capacity is limited and the veterans' needs temporarily exceed the VA's ability to deliver services in a timely fashion. This is a clear advantage to the veteran.

Myth Number 2

Project HERO reduces the need for the VA's current fee-basis offices and staff due to services being "outsourced."

Fact

Mr. Chairman, we have heard this concern for some time, and while at face value it may sound like a reasonable suggestion, there is one major reason it is not accurate. The reason is the way referrals or authorizations for care outside VA are provided to Humana Veterans under the HERO Model. All referrals provided to Humana Veterans are generated out of the fee-basis offices at local VA facilities. Once a VA physician sends a referral to the fee office, *it has already been determined that the VA does not have the capacity to provide for the care of the veteran.* In response, the fee office determines what specific services are required for a veteran, and then decides what avenues are available to the veteran for care rendered outside the VA. In contrast to the myth, and based on these well-established, longstanding processes, the fee office becomes indispensable in the process of generating HERO referrals or authorizations, not endangered by it.

Humana Veterans supports the Veterans Health Administration (VHA) in achieving delivery of *high quality, accessible, seamless,* and *cost effective* health care solutions to our Nation's veterans.

COST SAVINGS AND EFFICIENCIES

Efficiencies

The topic of efficiencies as it relates to health care for veterans generally results in a discussion about timeliness of the care provided. While that is undeniably one of the most important metrics and successes of HERO to date, efficiencies go well beyond how quickly a veteran is seen in a clinician's office.

A great deal of work goes into scheduling an appointment and making the veteran comfortable with the nature and location of his or her appointment. Having a reliable, credentialed network of providers sufficient to handle the care required in the community and providing a smooth clinical transition of the veteran back to their primary care provider at the VA is equally important.

The Humana Veterans provider network has grown to include over 30,000 providers across the four VISNs, including about 5,900 in rural and highly rural areas. A greater concentration of potential VA providers exists today than at any time in the past—for both urban and rural areas—because of Project HERO.

Cost Savings

Although we are not able to make a direct comparison to VA's costs for fee-based care, VA is benefiting from cost savings through Project HERO. Health care services provided under HERO are priced as a percentage of the applicable Medicare Fee Schedule. Under the current contract, 92 percent of all contract line items for health care services are priced below the corresponding Medicare Fee Schedule.

A comparison of our network costs to Medicare rates shows significant savings. Subjectively speaking, reimbursement rates under HERO are generally more favorable than the traditional fee-based structure at the VA, and commonly below Medicare reimbursement rates in the geographic regions where HERO is operational. We attribute this to:

1. Humana Veterans is respected in the civilian community and has developed a reputation for on-time payments to providers; and,
2. Even with the indefinite delivery/indefinite quantity (IDIQ) nature of the contract, Humana Veterans is successful in garnering deeper discounts, across the four VISNs, due to corporate presence, reputation and on-going relationships with provider groups.

It is important to state that even if the costs were the same for VA between Project HERO and the regular fee-based program, the advantage to Veterans through the HERO Model ensures personalized service, quality, timely access, and convenience resulting in superior value to the VA and veterans. There is a clear advantage in the HERO Model, which should be extended beyond the four VISNs and institutionalized nationally across VA facilities.

WHAT IS QUALITY VA HEALTH CARE?

I am sure that if you asked 10 veterans for their definition of quality health care in VA you would receive many different answers. The answers may differ significantly from a medical professional's definition. There are certain attributes, however, that would be common in most responses from veterans and form elements of quality VA health care. The elements would likely include:

1. Respect for the individual veteran and her or his service to our Nation.
2. State-of-the-art services from the health care provider.
3. A level of comfort that the provider is licensed and credentialed for the services provided.
4. Timely and convenient access to the provider.
5. Assurance that the community provider has access to the veteran's medical records, if needed, to ensure excellent continuity of care and to avoid the need for multiple incidents of the same test or procedure.
6. Timely return of the clinical information to the VA primary provider and inclusion in the electronic health record.

Humana Veterans works tirelessly with VA to ensure care provided through our HERO networks reflect the level of quality provided inside VA facilities, but our goal and the real goal of the demonstration, is to raise the bar compared to VA's traditional fee-basis care. A number of existing initiatives undertaken in the Project HERO Model contribute to this goal including personalized appointment services, timely access to care and the return of vital clinical information to VA.

Return of Clinical Information

Accurate accounting for outside consult reports and other clinical information is a critical component of quality health care. VA's decentralized approach to its normal fee-based care makes it difficult to track metrics on the timeliness of outside provider consult reports. Humana Veterans, in partnership with VA, has established a benchmark requirement for the return of clinical information to VA. Humana Veterans expends considerable administrative effort in tracking clinical consult reports and has established a standard for reports to be returned to VA within 30 days. This ensures that treatment information and test results contained in the clinical consult reports are available to the primary care VA providers. This is simply another indication of the quality that Project HERO brings to care delivered outside of VA facilities.

Currently, the process of entering clinical consult reports into VA's electronic health record is a manual process. In the future, the Project HERO Model could be institutionalized across VA, electronic consult records could be contractually required, entered directly into the system, and directed to the VA primary provider's desktop.

I would like to share some metrics associated with this largely electronic exchange. Based on our latest data extraction, reporting all data from the beginning of HERO in January 2008 through the end of December 2009 shows:

- Seventy-one percent of clinical information is returned within 15 days;
- Eighty-eight percent return of routine clinical information to the VA within 30 days of the HERO encounter;
- Ninety-five percent return of routine clinical information within 45 days; and
- For the return of clinical information to the VA, the median is 9 days.

More needs to be done to facilitate an increasingly electronic, workable exchange with Veterans Health Information Systems and Technology Architecture (VistA)/ Computerized Patient Record System (CPRS), the VA's electronic health record. However, we are convinced efforts made to date represent significant progress in enhancing the continuum of care for veterans outside of VA facilities through this project.

FUTURE OF THE HERO MODEL

I want to emphasize at this point that Humana Veterans and the VHA PMO for Project HERO have an excellent working relationship. The following recommendations are put forth to enhance Project HERO and are submitted for your consideration in legislating for a 21st Century Project HERO.

Approach Project HERO as a true demonstration project. Demonstration projects take on many forms, but most have the common attribute of implementing a procedure or set of procedures, an evaluation of the processes with sufficient workload to emulate real world conditions, and ultimately, the implementation of identified improvements. Then the process is replicated, using the newly-identified best practices and continually improving the model. We believe Congress desired such a demonstration process with the ultimate goal of improved service to veterans who are referred for evaluation or care in the community. VA implemented the Congressional directive by awarding a single contract for all four VISNs and simply administering the contract. There is currently no provision or contractual mechanism that allows for a mandatory workload adjustment after either (1) a specific period of performance; or (2) the effective implementation of improved processes. In other words, VA is not required to improve their larger, institutional processes as lessons are learned during the demonstration. Further, they are required only to send a minimal workload to the demonstration, thereby defeating the true purpose of a demonstration project, (i.e., testing new and innovative management initiatives and implementing best practices and lessons learned). There is still plenty of time, under HERO, to conduct a true demonstration project within the existing contract. Three years remain on the 5-year demonstration and a world class fee-based process can be realized if VA is willing to commit to realistic workloads and process adjustments to test proposed process improvements.

It is difficult to run a demonstration project when there is a competing process in the same fee office. We suggest that Project HERO become a first and preferred option in at least one VISN, perhaps VISN 8 or 16. Project HERO currently runs alongside VA's normal fee-based processes. The only manner to truly test the demonstration concept is to make referral to Project HERO the first or preferred option in a busy VISN fee office.

Access to VHA's CPRS. Currently, Humana Veterans as the project HERO contractor does not have access to VHA's Computerized Patient Record System (CPRS).

The written consult reports of the outside medical specialists are transmitted via secure email or faxed to VHA and either manually downloaded or scanned into CPRS. While this represents significant progress beyond VA's current fee-based efforts, this imperfect process can result in delay or lost records and remains subject to human error. VHA should be directed to provide direct access to CPRS for the Project HERO contractor. This will result in increased efficiencies, reduce the time for the written consult to be returned to the primary VA provider, and reduce delay in providing vital diagnostic and expert opinions to the veteran's VA primary provider. With direct access to CPRS, the contractor can enter an electronic or scanned consult into CPRS and send it directly to the VA primary care provider. It will also reduce the time it takes to provide a veteran's medical records required for the outside consult.

VA would benefit from standardized processes, procedures and forms. The existing fee-based process in VA is completely decentralized. Standard forms exist, but many are locally modified. Further, there is no standard language for authorizations for care outside VA. The phrase "Evaluate and Treat" means different things in different fee offices. Standard electronic forms and language would greatly enhance VA's legacy, fee-based system. Given the attributes mentioned in my testimony, Project HERO has the potential to go beyond its current form. However, the Model has not been adequately tested under conditions of a full-load of referrals. The numbers of Project HERO referrals continue to steadily decline and have for the past 6 months. It would be difficult to draw many conclusions on the ultimate future of HERO without a true test of its capabilities. The average monthly volume over the past 6 months has been 6,186 total from all four VISNs. A minimum number of referrals per month should be 10,000–12,000 in order to validate the HERO Model. We encourage the Committee to recommend VA utilize the services offered in Project HERO to the greatest extent practicable to enhance the demonstration project and validate the HERO Model.

In addition to increasing usage of the current HERO contract, we see other potential areas of benefit to veterans. These include:

1. Humana Veterans has established networks in areas VA might consider rural or highly rural. Given the emerging demographics as it relates to new veterans from Operations Iraqi and Enduring Freedom, our rural footprint could be advantageous as VA seeks to provide care closer to where the veteran population.
2. Women's health is another example of where we can positively affect the emerging requirements of the VA. Women are among the fastest growing segment of eligible veterans and their numbers are expected to double over the next 5 years. The VA may be at a disadvantage when it comes to building the requisite infrastructure to meet the emerging demands and requirements of women depending on the VA for care. Humana Veterans, due to our large reach into the provider community, could be an effective "backstop" for the VA when they lack the capacity to deliver this care.
3. Finally, we have made great progress ensuring veterans' clinical information is returned in a timely fashion to the VA after a clinical encounter with a HERO provider. It would be more effective if we could provide it electronically through VistA and have it compatible with CPRS as the VA is at the forefront of enterprise-wide electronic health records. We want to partner with the VA to ensure clinical information associated with the more than three billion dollars spent in clinical care provided outside of VA facilities, is increasingly available to providers inside the VA, thus improving the clinical continuum of care for our Veterans.

CONCLUSION

Mr. Chairman and Ranking Member Brown, I would again like to thank you for the opportunity to come before the Committee today to discuss, for the first time, the value Project HERO brings to veterans, and the value Humana Veterans adds through the HERO Model. I am confident at this early stage in the demonstration contract that Project HERO has delivered, and will continue to deliver, value on its three hallmarks: **Quality**, **Access** and **Cost** effectiveness. Our Nation's heroes deserve quality health care solutions and that is our ultimate mission at Humana Veterans.

Thank you, Mr. Chairman. I would be glad to answer any questions from the Committee.

EXHIBITS

Exhibit A: Project HERO Demonstration VISNs

Exhibit B: Management of Quality Care

Clinical Quality Management Committee (CQMC)

Humana Veterans understands the importance of ensuring quality health care delivery to our Nation's veterans. As a result, we initiated the Humana Veterans Clinical Quality Management Committee (CQMC).

The CQMC is an interdisciplinary committee that meets at least quarterly and comprised of Humana associates, VA representatives, and representatives of delegated CQM and Credentialing services. The CQMC oversees and directs activities of the Clinical Quality Management Program (CQMP) on behalf of the Humana Veterans Executive Committee. The CQMC acts as an interface between the VA and delegated subcontractors and ensures compliance with the VA contract. The findings of the CQMC are reported quarterly to the Humana Veterans Executive Committee.

Credentialing Committee (CC)

Credentialing of Humana Veterans providers is performed by the Credentialing Committee. The Credentialing Committee is responsible for evaluating the qualifications of professional health care practitioners based on appropriate industry standards. Evaluations may include data related to alleged misconduct, performance or competence of a provider. The committee reviews credentialing reports and makes final determinations on all provider applicants and delegated groups. The re-credentialing of contracted providers is conducted at least every 3 years. The decision to accept, retain, deny or terminate a provider shall be at the discretion of the committee, which meets as often as necessary to fulfill its responsibilities.

Patient Safety Peer Review Committee (PSPRC)

The Humana Veterans PSPRC provides peer review for any potential clinical quality of care issue identified and delineates steps to resolve problems and the ongoing monitoring of these issues. The committee performs peer review of patient safety and quality of care issues identified through the Potential Quality Indicator (PQI) process and provides input for communicating and educating providers of concerns related to patient safety or clinical improvement. Upon confirmation of a qual-

ity issue the PSPRC will assign an appropriate severity level, determine intervention(s) to address the issue, and review and monitor intervention(s) to completion.

The levels of severity utilizes by Humana Veterans include:

Level	Adverse Effect On Patient
1	Quality issue is present with minimal potential for significant adverse effects on the patient.
2	Quality issue is present with the potential for significant adverse effects on the patient.
3	Quality issue is present with significant adverse effects on the patient.
4	Quality issue with the most severe adverse effect(s) and warrants exhaustive review.

Quality issues with minimal potential for significant adverse effects on the patient are assigned a Severity Level 1 by the Chief Medical Officer. This information is entered into the Provider Trend Database (PTD) for tracking and trending purposes. Cases assigned a Severity Level 2 are presented in summary to the committee for informational purposes and entered into the PTD. Cases recommended as a Severity Level 3 or 4 are presented to the committee for peer review and final determination.

Prepared Statement of P.T. Henry, Senior Vice President, Federal Government Programs, Delta Dental of California

Mr. Chairman, Members of the Subcommittee, I would like to thank you for inviting us to join you this morning to talk about our Partnership with the Department of Veterans Affairs in the execution of the demonstration project on Healthcare Effectiveness through Resource Optimization (Project HERO).

Delta Dental is the Nation's oldest and largest provider of Dental Services. Through our 39 independent member plans, we provide dental insurance coverage to over 54 million people in all 50 States, the Commonwealth of Puerto Rico, the Territories and other overseas locations. Four out of every five dentists are affiliated with Delta Dental and our network of approximately 140 thousand highly qualified dentists is second to none. Of those, approximately 19,000 are located in the four Project HERO Veteran Integrated Service Networks (VISNs).

Delta Dental first began a journey in the late 1970s with the then Veterans Administration when we administered the VA Outpatient Dental Care Program (Fee Basis) in California. Over the years our involvement with the Department has ebbed and flowed. What has not changed, however, is our total commitment to the tremendous men and women who serve our Nation in uniform. Today, it is both a privilege and an honor for us to administer this program in collaboration with the Veterans Health Administration and the four participating VISNs.

We fully understand and are committed to the goals of Project HERO as articulated in the underlying statute, the implementing contract and related documents. At Delta, we see our role not as a substitute for VA Care but rather as an extension of that care when, for whatever reason, required care cannot be provided at the VA's dental treatment facilities.

By making available our networks of Delta Dental providers, we complement VHA's in-house capacity with high quality, credentialed providers with whom we have negotiated discounted rates. Basically, we believe Project HERO will, in the long run, lay the foundation that will allow the VHA to provide necessary care to more veterans for less money than is currently paid for Fee Care.

We work in close collaboration with our partners in the Dental Clinics, in the VISNs, and the VHA to improve the exchange of clinical information between our network community providers and the various elements of the VHA. While fostering high quality care and patient safety, we improve veteran satisfaction and can provide avenues based on commercial business practices to control costs and eliminate waiting lists. We see this in stark contrast to traditional "FEE CARE" in which the VA has no influence over the quality of care yet pays "Billed Charges" for all work done.

During the period from January 2008 through December 2009 we have received 20,898 viable authorizations which resulted in our making 20,753 appointments for

care. Of those, about 18,772 have been seen by a dentist and we have received a claim for the dental services rendered. The remainder has received treatment for which we have not yet been billed or are awaiting their scheduled appointment.

Once treatment has been authorized, our veterans are in the dentist chair on average in 18 days and, 99.82 percent are seen in less than 30 days for the calendar year 2009. We see this as a clear indication that the program is meeting the established objectives. We are proud of this track record and expect it to improve as we work through the remaining years of the demonstration.

We believe that a key to this success has been the partnership forged between Delta Dental and the VHA to ensure that this demonstration program provides a solid foundation for future decisions about veteran's dental care.

During the 25 months since contract award, we have worked to better understand the culture, attitudes and expectations of our partners while exposing them to the benefits that private sector dental plans can provide. There have been, and will be of course, bumps in the road. Together we are working our way through them so we move towards the common goals of Project HERO.

As we look forward, together with our partners in VHA, we have identified specific areas for procedural improvements that will enhance the overall contribution of the dental portion of Project HERO to the care provided to our veterans.

These areas include:

> Empowering the Chief, Business Office and Project HERO PMO, under the oversight of the VHA and VA's Office of Dentistry, to manage the administration of the program and enhance the standardization of policies and procedures across VISNs and Medical Centers. If Project HERO is to successfully harness the benefits of leveraging a nationwide private sector resource, the Project cannot be operated like 32 individual dental plans, each operating with its own rules and expectations.
>
> Maximizing the referral of patients, who would otherwise be referred to Fee Care, to Project HERO network dentists. Artificially limiting at a local level the selection of veterans referred to Project HERO dentists while continuing to rely on Fee Care for a preponderance of those veterans authorized to receive care outside the VA hospitals and clinics will skew the results of the pilot and magnify the impact of adverse selection on the overall results.

We at Delta, from the mailroom to the Executive Offices, appreciate all you have done and continue to do for the tremendous men and women who have served our Nation in uniform. Thank you, again, for the opportunity to appear before you today.

Prepared Statement of Gary M. Baker, MA, Chief Business Officer, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman, Mr. Ranking Member, Members of the Subcommittee: thank you for providing me this opportunity to discuss the Department of Veterans Affairs' (VA) demonstration Project on Healthcare Effectiveness through Resource Optimization (Project HERO). I am accompanied today by Ms. Patricia Gheen, Deputy Chief Business Officer for Purchased Care, and Mr. Craig Robinson, Executive Director and Chief Operations Officer for VA's National Acquisition Center.

Given our focus on providing patient-centered care and recognizing that we may not always be able to provide Veterans in every location with ready access to 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 focused upon improving that management. Project HERO is a cornerstone of those efforts.

House Report 109–305, the conference report to accompany the Military Quality of Life and Veterans Affairs Appropriations Act of 2006 (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 also encouraged VA to collaborate with industry, academia, and other organizations to incorporate a variety of public-private partnerships.

Project HERO is in year 3 of a proposed 5-year contracting pilot to increase quality oversight and decrease the cost of purchased (fee) care. The program is currently

available in four Veterans Integrated Services Network (VISNs): 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). Historically, these VISNs have had high expenditures for non-VA purchased (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 our most comprehensive and ambitious pilot program. It is intended to improve the management and oversight of the purchase of non-VA health care services. Through Project HERO, VA contracts with Humana Veterans Healthcare Services (HVHS) and Delta Dental Federal Services (Delta Dental) to provide Veterans with pre-screened networks of providers, principally 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, diagnostic and other services that are not always available in VA. For every patient, VA Medical Centers determine and authorize specific services and treatments referred 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 (PMO) 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 the demonstration; and
- Sustain partnerships with Academic Affiliates.

The VHA Chief Business Office oversees purchased care programs, including fee care and Project HERO. The Chief Business Office meets with internal and external stakeholders and monitors and evaluates program metrics. VA established a Project HERO Governing Board which oversees program activities. It is composed of the Deputy Under Secretary for Health Operations and Management, the VHA Chief Business Officer, and Network Directors from the four participating VISNs. The Governing 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 medical documentation to VA, patient safety and satisfaction. The PMO conducts contract administration, project management, performance and quality management; data analysis, reporting and auditing; and communication and training.

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

- Credentialing and accreditation;
- Timely reporting of access to care;
- Timely return of medical documentation 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.

HVHS uses patient safety indicators, developed by the Agency for Healthcare Research and Quality, as well as complaints and referrals 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 the VA Survey of Healthcare Experiences of Patients (SHEP), Joint Commission measures, and proxy measures based on Healthcare Effectiveness and Data Information Set (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 rates in the National Dentistry Advisory Service Comprehensive Fee Report for dental services.

While Project HERO is only in the third year of a 5-year pilot, the program is meeting its objectives of improving quality oversight, access, accountability and care coordination. As a demonstration project, Project HERO has provided VA with 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. Through the third quarter of FY 2009, overall satisfaction with Project HERO care through HVHS was 77 percent and 86 percent for Delta Dental.
- Costs are generally comparable to VA costs for other non-VA fee care. Project HERO savings, including value-added fees, are estimated at more than $2.5 million from January 2008 to September 2009.
- HVHS and Delta Dental providers meet VA credentialing standards and 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, defined as within 30 days, providing specialty or routine care 90 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. While HVHS and Delta Dental are not meeting the 100 percent standard, the contracts provide a vehicle for tracking return of medical documentation that did not exist previously in fee care and we are seeing monthly progress. In November 2009, HVHS met this metric more than 90 percent of the time, while Delta Dental returned requested treatment plans to VA within 10 calendar days more than 74 percent of the time.
- 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, participating VA Medical Centers report that they have not reduced staff due to the introduction of the Project HERO contracts.

Using a contract vehicle allows VA to impose these specific and rigorous requirements consistently among providers, resulting 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.

Mr. Chairman, we appreciate the opportunity to discuss this initiative with you. My colleagues and I are available for your questions.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
February 16, 2010

Mr. Sidath V. Panangala
Specialist in Veterans Policy
Congressional Research Service
The Library of Congress
101 Independence Avenue, SE
Washington, D.C. 20540

Dear Mr. Panangala:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Review of VA Contract Health Care: Project HERO" that took place on February 3, 2010.

Please provide answers to the following questions by March 30, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In your testimony, you explained that the conference report language accompanying the 2006 Appropriations Act for Veterans Affairs directed VA to establish "managed care" demonstrations. However, the VA developed a set of objectives that led to a demonstration project to enhance the existing fee basis care program.
   a. Please expand on their point. Since VA awarded the Project HERO contract to Humana and Humana is a managed care company, isn't VA testing the "managed care" model as required by the conference report language?
   b. Is VA were to implement a purely "managed care" model, how would it differ from the current implementation of Project HERO?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by March 30, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Congressional Research Service
Washington, DC.

Memorandum

May 14, 2010

To: House Committee on Veterans' Affairs, Subcommittee on Health
Attention: Jeff Burdette
From: Sidath Viranga Panangala, Specialist in Veterans Policy, 7–0623
Subject: Review of VA [Department of Veterans Affairs] Contract Health Care: Project HERO—Responses to Post-Hearing Questions

Introduction

This memorandum is provided in response to the post hearing questions submitted to the Congressional Research Service (CRS) by the House Committee on Veterans' Affairs, Subcommittee on Health, following the oversight hearing on Project HERO (Health Care Effectiveness through Resource Optimization) held on February 3, 2010, where CRS provided testimony on the implementation of Project HERO. The questions have been restated here and the response follows each question.

Questions and Responses

Question 1: "In your testimony you explain that the conference report language accompanying the 2006 Appropriations Act for Veterans Affairs directed VA [Department of Veterans Affairs] to establish "managed care" demonstrations. However,

the VA developed a set of objectives that led to a demonstration project to enhance the existing fee basis care program."

Question 1 (a) "Please expand on [this] point. Since VA awarded the Project HERO contract to Humana and Humana is a managed care company, isn't VA testing the "managed care" model as required by the conference report language?"

Answer: Prior to addressing this question it is essential to briefly discuss the characteristics and types of managed care. Current managed care plans are based on managed care concepts that have been evolving over time. While there is no specific definition of managed care in the academic literature, most definitions generally characterize "managed care as a range of utilization and reimbursement techniques designed to limit costs while ensuring quality of care."[1] Managed care can involve a wide variety of techniques which includes, among other things, various forms of financial incentives for providers, early identification of disease, and promotion of wellness.[2] A wide variety of organizations could implement managed care techniques.[3] In general, managed care organizations (MCOs) attempt to reduce costs by focusing on lowering the price paid to providers, limiting the volume of care rendered to beneficiaries, and reducing the intensity of health services used.[4]

In the early 1990's the various types of MCOs were somewhat distinct. Since then the differences between traditional forms of health insurance and MCOs have narrowed to the point where it is very difficult to distinguish whether an entity is an insurance company or an MCO. On one end of the continuum are managed indemnity plans which require some level of precertification of care especially for elective procedures.[5] Further along the continuum are preferred provider organizations (PPOs)[6] and point of service plans (POS).[7] Towards the other end of the continuum are Health Maintenance Organizations (HMOs).[8] It should be noted here that the structure of HMOs has also expanded to include models such as group-model HMOs and network-model HMOs, among others. A thorough discussion of these models is beyond the scope of this memorandum.[9] In general, PPOs POSs, and HMOs, have an established provider network, negotiated payment rates for providers, utilization management programs to control the cost and use of health care services, and a gatekeeper function for coordinating and authorizing all medical services, laboratory studies, specialty referrals and hospitalizations referrals, among other characteristics. It should be noted that since the mid 1990's the VA health care system has

[1] Steven Berger, *Fundamentals of Health Care Financial Management: A Practical Guide to Fiscal Issues and Management,* 3rd ed. (San Francisco, CA: Jossey-Bass, 2008), p. 146.

[2] Peter D. Fox, "An Overview of Managed Care," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 4.

[3] Ibid.

[4] Steven Berger, *Fundamentals of Health Care Financial Management: A Practical Guide to Fiscal Issues and Mana*gement, 3rd ed. (San Francisco, CA: Jossey-Bass, 2008), p. 92.

[5] Eric R. Wagner, "Types of Managed Care Organizations," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 19.

[6] A PPO is an entity through which employer health benefit plans and health insurance carriers contract to purchase health care services for covered beneficiaries from a selected network of participating providers. Typically, participating providers in PPOs agree to abide by utilization management and other procedures implemented by the PPO and agree to accept the PPO's reimbursement structure and payment levels (Eric R. Wagner, "Types of Managed Care Organizations," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 20).

[7] A POS is a plan in which members do not have to choose how to receive services until they need them, and are allowed to choose a provider outside the main panel of providers without the referral from a primary care physician. Services received outside of the main panel include higher deductible, coinsurance or copayments (Eric R. Wagner, "Types of Managed Care Organizations," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 22; and Steven Berger, *Fundamentals of Health Care Financial Management: A Practical Guide to Fiscal Issues and Management*, 3rd ed. (San Francisco, CA: Jossey-Bass, 2008), p. 150).

[8] HMOs are organized health care systems that are responsible for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. In general an HMO can be viewed as a combination of a health insurer and health care delivery management system (Eric R. Wagner, "Types of Managed Care Organizations," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 23).

[9] For more details on managed care, see CRS Report RL32237, *Health Insurance: A Primer,* by Bernadette Fernandez.

utilized managed care principles that have been tailored to the complex needs of the VA's service population.[10]

As stated in the CRS report on Project HERO (which was submitted for the record), in 2006, Congress directed VHA to implement a contracting pilot program to better manage the fee basis care program.[11] The conference report (H. Rept. 109–305) to accompany the Military Quality of Life and Veterans Affairs Appropriations Act, 2006 (P.L. 109–114) called for VA to: [12]

- Implement care management strategies proven valuable in public and private sectors;
- Ensure care purchased for enrollees from community providers is cost-effective and complementary to the larger VA system of care;
- Preserve important agency interests, such as sustaining partnerships with university affiliates;
- Establish at least three care management demonstration programs through competitive award; and
- Collaborate with industry, academic, and other organizations to incorporate a variety of public-private partnerships.

As stated before, the VA health care system utilizes managed care principles. Project HERO is a demonstration program that is being piloted in Veterans Integrated Services Network (VISNs) 8, 16, 20 and 23 to improve the ability of VA to care for the Department's enrolled veterans.[13] According to the contract, under the demonstration, VA is to take steps to maximize the care it provides directly and better manage fee basis care.[14] A central goal of Project HERO is to ensure that all care delivered by VA—whether through VA providers or through community providers—is of the same quality and consistency for veterans. Under Project HERO, VA continues to manage the care of individual patients. Humana Veterans Healthcare Services (HVHS), Inc. maintains a network of providers in the local community who are intended to be responsive to the care needs identified by each of the participating VISNs and to complement the care provided within each VISN. Furthermore, according to the contract, services will only be acquired when VA staff cannot provide the service. Therefore, under the contract with HVHS, the Department continues to manage the care of the individual patient. HVHS does not control the utilization of services nor does it function as a gatekeeper, which generally are characteristics of MCOs. Based on the characteristics of MCOs, as previously described, it appears that the current contractual relationship with HVHS cannot be directly categorized as a managed care demonstration.

Question 1 (b) "[If] the VA were to implement a purely "managed care" model, how would it differ from the current implementation of Project HERO?"

Answer: As discussed previously, there is no clear distinction or boundary between various managed care models and traditional indemnity insurance plans. Furthermore, some controversy exists over whether the term "managed care" accurately describes the new generation of health care delivery and financing mechanisms.[15] Currently, under Project HERO, veterans receive primary care at their local VA health care facility. If a VA health care provider determines that the specific medical expertise or technology is not readily available at the local facility then the provider requests that the service be obtained from a non-VA provider. The consult request is reviewed by the fee basis care Chief Medical Officer (CMO) and, if the CMO concurs, the request proceeds to the fee basis care program office. At this

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[10] Kenneth W. Kizer, John G. Demakis, and John R. Feussner, "Reinventing VA Health Care: Systematizing Quality Improvement and Quality Innovation," *Medical Care*, vol. 38, no. 6 (June 2000), p. I10.

[11] CRS Report R41065, *Veterans Health Care: Project HERO Implementation,* by Sidath Viranga Panangala.

[12] U.S. Congress, Conference Committee, Making Appropriations for Military Quality of Life Functions, of the Department Of Defense, Military Construction, the Department Of Veterans Affairs, and Related Agencies for The Fiscal Year Ending September 30, 2006, and for Other Purposes, Report to accompany H.R. 2528, 109th Cong., 1st sess., November 18, 2005, H. Rept 109–305, pp. 43–44.

[13] The conference report (H. Rept. 109–305) to accompany the Military Quality of Life and Veterans Affairs Appropriations Act, 2006 (P.L. 109–114) called for VA to establish at least three demonstration programs. VA established the demonstration in four sites under the umbrella of one program.

[14] Amendment of Solicitation/Modification of Contract, VAI01049A3–P–0270, October 1, 2007.

[15] Eric R. Wagner, "Types of Managed Care Organizations," in *The Essentials of Managed Health Care,* ed. Peter R. Kongstvedt, 4th ed. (Gaithersburg, MD: Aspen Publishers, 2001), p. 19.

point in the process, the fee basis care program office determines whether to send the referral to Project HERO (based on whether the services are provided within a reasonable distance under Project HERO), and if so sends an authorization for care to HVHS.[16]

Generally, authorizations are provided to HVHS for each episode of required care. In contrast to the regular fee basis care program in which the veteran selects his or her own provider, under Project HERO HVHS contacts the veteran by phone to schedule an appointment with an HVHS network provider. During this process appointment details are communicated back to the referring VA health care facility, and the veteran receives a letter with appointment details and instructions. HVHS coordinates the transfer of any required pre-visit clinical information from the local VA medical facility to the HVHS network provider. After the veteran is seen by the HVHS network provider, and if additional services are needed, HVHS sends a request back to the referring VA medical center for authorization. Under the contract, HVHS is required to return clinical information from the visit back to the referring VA medical facility—typically within 30 days of the appointment. Therefore, under the current Project HERO implementation model, HVHS enhances the care coordination for veterans who receive authorized care outside of the VA health care system.

Implementing Project HERO under any one of the three broad MCO models (that is, PPO, POS, or HMO), would mean that the VA would enroll a certain number of veteran patients with a MCO. The MCO would then be responsible for the provision of all health care services to those veteran patients, compared to an episode by episode basis as it is currently done under Project HERO. VA could reimburse the MCO based on a negotiated rate or on under a capitated payment system.[17] Shifting the responsibility of care to a MCO, could raise potential issues on how care is delivered to veteran patients. For instance, the MCO could employ utilization management techniques to control costs of health services provided to their covered veteran patients, and have a greater degree of control over the care of those veteran patients. Whereas under the current Project HERO implementation model, utilization of health care services by veterans rests exclusively with the VA, since authorizations are provided to HVHS for each episode of required care.

Furthermore, potential access issues could arise depending on how the MCO negotiates reimbursement rates with a provider network. For instance, if the MCO is unable to recruit a provider network due to low reimbursement rates, veterans may be faced with delays in accessing care. However, if the MCO has a large credentialed provider network, veterans could receive care closer to where they reside.

Currently, VA uses health information technology in the management of patient care. All services received from VA are recorded in the patient's medical record; this information is available to the patients primary care provider as well as other VA providers who see the patient. By moving care outside the VA health care system to a MCO there could be potential situations where medical information may not be readily available for VA health care providers when veterans seek more specialized care from the VA. Although, currently HVHS is required to return clinical information from the visit back to the referring VA medical facility—typically within 30 days of the appointment, there may be less of an incentive for a MCO to return clinical information to the VA once it has a larger enrollee veteran population and a greater degree of control over the care of those veteran patients.

Lastly, the VA health care system also has affiliations with academic medical institutions. VA's clinical training program is the largest provider of health care training in the United States. Of the total U.S. physician residents about 31 percent (34,075) receive some or all of their training from the VA annually.[18] Under affiliation agreements, VA clinicians may be granted academic appointments to medical school faculty at the discretion of the academic institution based on the clinician's credentials. Currently, about 67 percent of VA clinicians at affiliated VA medical

[16] It should be noted that each of the pilot VISNs has inter- and intra-VISN referral policies. For example, if a specific VA medical facility cannot provide the required services, the next step would be to see if another facility within the VISN, and within reasonable distance to the veteran, could provide that specific service or if an academic affiliate or Department of Defense (DoD) sharing agreement could be used to provide that service. If these options are not available then the referring VA medical facility could authorize the use of Project HERO or non-Project HERO fee basis care.

[17] Capitation payment systems are based on the number of people to be served by the provider. Here, the VA pays a monthly per-capita payment to the provider institution to deliver a package of services to enrolled veterans.

[18] Department of Veterans Affairs, Veterans Health Administration, Office of Academic Affiliations, Briefing to the Congressional Research Service, April 15, 2009.

centers have faculty appointments.[19] Shifting veteran patients to a MCO could potentially affect VA's existing relationships with academic health systems in the U.S., and may hinder the recruitment of clinicians to the VA as well.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
February 16, 2010

Ms. Belinda Finn
Assistant Inspector General for Audit and Evaluations
Office of the Inspector General
U.S Department of Veterans Affairs
1114 I Street, N.W.
Washington, D.C. 20002

Dear Ms. Finn:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Review of VA Contract Health Care: Project HERO" that took place on February 3, 2010.

Please provide answers to the following questions by March 30, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. In Ms. Finn's audit of the non-VA Outpatient Fee Care Program, she identified improper payments and found that the VA lacked documents justifying the use of the Outpatient Fee Care Program. Do your findings suggest that the VA may have improperly authorized the use of fee basis care, thereby improperly violating the statutory requirements that certain conditions must be met before the VA can authorize fee basis care?
2. Do you believe that the issues identified in your audit would be alleviated if the VA were to enhance the existing fee-basis care program with certain elements of the Project HERO demonstration project?
3. Clearly some of the VAMCs did not properly follow VHA policy regarding outpatient fee claims. It is hard to imagine that at the director level, there is not more compliance with the policy that is in place and more oversight. Besides an adequate follow-up plan and implementation by VA to correct some of the issues, does the IG have plans to go back and look at this program to see if improvements have been made?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by March 30, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

U.S. Department of Veterans Affairs
Office of Inspector General
Washington, DC.
March 25, 2010

The Honorable Michael H. Michaud
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your February 16, 2010, letter following the February 3, 2010, hearing on *Review of VA Contract Health Care: Project HERO.* Enclosed is our response to the additional hearing questions. This information has also been pro-

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[19] Ibid.

vided to Congressman Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

GEORGE J. OPFER
Inspector General

Enclosure

[An identical letter was sent to Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health, Committee on Veterans' Affairs.]

Questions for Ms. Belinda Finn, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, U.S. Department of Veterans Affairs, Before the Subcommittee on Health, Committee on Veterans' Affairs

Hearing on Review of VA Contract Health Care: Project HERO

Question #1: In Ms. Finn's audit of the Non-VA Outpatient Fee Care Program, she identified improper payments and found that the VA lacked documents justifying the use of the Outpatient Fee Care Program. Do your findings suggest that the VA may have improperly authorized the use of fee basis care, thereby improperly violating the statutory requirements that certain conditions must be met before the VA can authorize fee basis care?

Response: Although the Veterans Health Administration (VHA) was not complying with their policy of formally documenting the justification and authorization of fee care in the veteran's medical records, we concluded they met the justification conditions of the statute.

VA can justify the use of fee care if VA does not have the capability or capacity to provide the service or the service is geographically inaccessible for the veteran. In the absence of a formally documented justification, we reviewed each veteran's medical record to determine if the attending physician's comments, the veteran's medical condition, and the distance from a VA facility would justify the use of fee care. We concluded that the justifications were adequate for the claims reviewed.

The authorization process is a control that ensures that the fee request is appropriate and medical facility management is aware of fee services being utilized. Although we found that VHA did not consistently follow its authorization process, we did not consider this a violation of statutory requirements.

We have an audit in progress examining the effectiveness of VHA's management of the non-VA inpatient fee care program. The audit includes a review of whether VHA is authorizing inpatient fee care according to the statutory requirements as well as determining the accuracy of claims payment. We plan to issue a report in late May 2010.

Question #2: Do you believe that the issues identified in your audit would be alleviated if the VA were to enhance the existing fee-basis care program with certain elements of the Project HERO demonstration project?

Response: Using certain elements of Project HERO could improve some of the payment issues discussed in the report. For example, the consistent use of contracted rates, such as in Project HERO, would make it easier for fee staff to determine the correct payment amount with fewer errors. Fee staff would only need to ensure that care provided and billed by Project HERO matches the care VA authorized.

Using a Project HERO approach would not, however, improve other issues discussed in the report. VHA would still remain responsible for properly justifying and authorizing appropriate fee care. Further, duplicate payments would not automatically improve under a Project HERO approach.

Question #3: Clearly some of the VAMCs did not properly follow VHA policy regarding outpatient fee claims. It is hard to imagine that at the director level, there is not more compliance with the policy that is in place and more oversight. Besides an adequate follow-up plan and implementation by VA to correct some of the issues, does the IG have plans to go back and look at this program to see if improvements have been made?

Response: We are currently reviewing VA's fraud management program for the fee care programs and auditing payments for inpatient fee care. We will continue to follow-up on actions from this audit and conduct future audits of the fee care program to determine how well corrective actions are leading to program improvements.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
February 16, 2010

Mr. Tim S. McClain
President and Chief Executive Officer
Humana Veterans Healthcare Services, Inc.
500 W. Main Street
Louisville, KY 40201

Dear Mr. McClain:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Review of VA Contract Health Care: Project HERO" that took place on February 3, 2010.

Please provide answers to the following questions by March 30, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. An independent evaluation is needed to fully assess whether Project HERO improved access to care and led to positive changes in the quality of care provided to our veterans. In the absence of such an evaluation, do you have supporting data and specific examples to support Project HERO having accomplished or having the potential to accomplish improved access and quality of care?
2. Some of the VA staff implementing Project HERO have shared with the Subcommittee their personal impressions that they do not see significant differences in administrative costs associated with Project HERO compared to traditional fee care. We have also heard stories of Project HERO not being necessarily more efficient, since the staff spends the same amount of time on Project HERO case as fee-basis cases. How do you response to these concerns?
3. The Subcommittee has also heard concerns from VA personnel about the lack of continuity of care. This is because VA primary care doctors cannot have direct contact with Humana providers, as the contractual relationship is between Humana and the non-VA provider. Is this a valid concern?
4. Subcommittee staff have been told that some non-VA providers are interested in participating in Project HERO but are unaware of how to be a part of the network. Related to this, we learned of some VISNs that had informal networks for specialty care but that Humana had a difficult time expanding its network in the same area. Has Humana largely addressed the network development concerns or does this continue to be a challenge?
5. It is apparent that you see the promise and potential of Project HERO to improve care for our veterans. Do you believe that the Project HERO model is ripe for implementation in other VISNs? Or, do you believe that the model needs to be fine-tuned more before it is expanded to other VISNs? If further refinements are needed, what are some examples of these refinements?
6. In your testimony you stated that you have seen a decline in the number of Project HERO referrals for the past 6 months when there should be about 10–12,000 in order to validate the HERO model. Can you explain what you mean and provide practical solutions on how to increase referrals?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by March 30, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Humana Veterans Healthcare Services
Louisville, KY
March 29, 2010

Honorable Michael H. Michaud
Chairman, Subcommittee on Health
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Michaud:

Thank you for the opportunity to testify at the Subcommittee's hearing on February 3, 2010 entitled "Review of VA Contract Health Care: Project HERO." This letter is in response to your correspondence dated February 16, 2010 requesting responses to certain post-hearing questions. The attached provides your questions and my specific responses for the record.

Thank you again, Mr. Chairman, for the opportunity to address these very important issues for Veterans. Humana Veterans considers it an honor each day to serve America's heroes in such a personal manner. We look forward to continuing our vital role in veterans health care services and expanding the Humana Veterans Personalized Services Model in VA. If you have any further questions, please do not hesitate to contact me at tmcclain2@humana.com or (502) 301–6984.

Sincerely,

Tim S. McClain
President and CEO

Attachment

Responses of Tim S. McClain, President and CEO, Humana Veterans Healthcare Services, Inc. to Post-Hearing Questions from Subcommittee on Health hearing on Feb. 3, 2010 entitled "Review of VA Contract Health Care: Project HERO"

Question #1: An independent evaluation is needed to fully assess whether Project HERO improved access to care and led to positive changes in the quality of care provided to our veterans. In the absence of such an evaluation, do you have supporting data and specific examples to support Project HERO having accomplished or having the potential to accomplish improved access and quality of care?

Response: Humana Veterans has specific data on improved access and quality of care under the Project HERO contract. Humana Veterans maintains a data repository called DataMart which contains the data for all contract performance metrics plus additional data that is designed to enhance delivery of services. Unfortunately, Humana Veterans possesses very little internal VA data on metrics related to access to care for Veterans under traditional fee basis care, which makes it difficult to make direct comparisons that illustrate improved access and quality of care under Project HERO. However, Humana Veterans offers the following supporting data and comments concerning performance under Project HERO.

Access Highlights:

- In February 2010, 93.4 percent of Veterans were seen by a community provider within 30 days of the VA authorization under Project HERO. Once Veterans were at the provider's office, 99.9 percent waited less than 20 minutes to be seen by the provider.
- For Project HERO inception-to-date performance, 90 percent of Veterans were seen by a community provider within 30 days of the VA authorization and 99.9 percent of all Veteran appointments required a wait time of less than 20 minutes.
- The 'access' supporting data is all the more impressive considering 43 percent of Veterans seen through Project HERO live in rural or highly rural communities where access to quality health care is scarce and in high demand.

Quality of Care Highlights:

- In February 2010, 92.9 percent of Veterans' clinical information was returned to the ordering VAMC within 30 days and 98 percent was returned within 45 days.

- For Project HERO inception-to-date performance, 89 percent of Veterans' clinical information was returned to the ordering VAMC within 30 days and 95 percent was returned within 45 days.
- Monthly complaints against providers and/or provider staff are less than 0.2 percent of appointments.
- Over 30,000 providers participate in Humana Veterans' credentialed provider network.

Veteran Satisfaction:

Veterans provided an overall rating of 64 percent for Humana Veterans provider specialists. The overall satisfaction rate with VA health care reported in the Survey of Healthcare Experiences of Patients (SHEP) was 62 percent. Overall quality of Project HERO is rated higher than VA SHEP.

Improving Veteran Access to Outside Services:

The Humana Veterans Personalized Services Model provides assistance to veterans in accessing qualified providers and scheduling appointments with those specialists. Humana Veterans facilitates access to a credentialed network of providers that currently totals in excess of 30,000 in the four demonstration VISNs. This personal touch has resulted in a very low "No-Show Rate," which is one indication of access to quality care. Although we do not have reliable no-show rate for VA's Fee Based Care, we can compare the Project HERO rate with a comparable population (e.g., TRICARE beneficiaries with specialist appointments with civilian providers outside of military treatment facilities). The No-Show Rate for TRICARE beneficiaries is estimated from various sources as 24 percent, whereas the No-Show rate for Veterans under Project HERO is only ***8 percent.*** The Patient Appointing component of Project HERO not only offers Veterans an appointment with an outside provider within 30 days of Humana Veterans' receipt of the referral ***92 percent*** of the time, but it also utilizes a live person to coordinate appointments between the provider and the Veteran, thereby resulting in a remarkably low No-Show rate.

I believe the Personalized Services Model adds significant value to the Veterans patient and reduces the stress to the Veteran when referred for specialty care or diagnosis. In many instances in VA's regular Fee Based Care program, a Veteran is given an authorization by the Fee Office and told to find a provider, schedule an appointment and return to the VA afterwards. Many Veterans are not familiar with how medical offices function or how they schedule appointments. The Personalized Services Model provides the Veterans with an advocate for patient appointing and consult return. The Model significantly improves the Veteran's overall experience and ensures the timely return of the specialist's consult report, thereby contributing to continuity of care in the VA.

Communications between VA and Outside Providers:

VAMC providers often send Veterans to outside providers to obtain specialist and subspecialist clinical opinions. Those written opinions (written consults) are of limited value to VAMC providers unless they are returned in a timely fashion. In the consult return component of the Project HERO program, Humana Veterans actively searches for and retrieves those consults from outside providers and sends them via secure e-mail back to the VAMCs where they are entered into CPRS so that primary care providers have timely and ready access to them. Humana Veterans returns these consults to VAMCs within 30 days ***89 percent*** of the time. This landmark contractual requirement of Project HERO dramatically enhances the continuity of care for Veterans and represents significant progress beyond traditional VA Fee-Based Care, where little clinical data is shared between outside providers and VA primary care providers.

Addressing Special Provider Needs of VAMC Providers:

In order to extend the same level of exemplary VAMC care to Veterans when services are required from providers outside of the VAMC, VA providers frequently request special services or providers with special requirements. Humana Veterans has been able to fulfill these special requests.

Some of those recent efforts are listed below.

Special Services Requested	Location
Sleep study interpretations from providers certified by American Academy of Sleep Medicine	Tampa
MOHS (i.e., skin cancer surgery) providers who are certified by American College of MOHS Surgery	Tampa
Open MRI studies stratified by magnet strength	Fayetteville
Neuromuscular & Electrodiagnostic Medicine studies matched to providers	New Orleans
Certification requirements for sleep labs	Fargo

Uniformity in the Delivery of Fee Based Care:

With Project HERO, a degree of uniform access to care across the four VISNs that has heretofore been unavailable is now achieved:

- Outside providers have been subjected to a rigorous and uniform credentialing process based upon URAC accredited credentialing processes;
- Standards of practice have been adopted on behalf of all VISNs for certain services (i.e., dermatology referrals and biopsies, neurodiagnostic studies, split sleep studies);
- Providers are subject to continuous clinical oversight by a Patient Safety and Peer Review Committee composed of civilian and VAMC providers; and,
- Standards for patient appointing, consult returns, urgent referrals, and Standards of Practice protocols are applied uniformly to all VAMCs in all four VISNs.

Conclusion:

Without available data from the VA addressing "No-Show rates", consult return performance, and responsiveness of outside providers to the VA's special requirements, it is difficult to make direct quantitative comparisons of Project HERO and VA's normal fee based procedures. However, based upon our experience to date, we believe there is no doubt that Project HERO has significantly improved Veterans access to care and improved quality. Indirect measures (e.g., patient satisfaction) and proxy measures from related programs (e.g., TRICARE) indicate that the improvements are substantial.

Question #2: Some of the VA staff implementing Project HERO have shared with the Subcommittee their personal impressions that they do not see significant differences in administrative costs associated with Project HERO compared to traditional fee care. We have also heard stories of Project HERO not being necessarily more efficient, since the staff spends the same amount of time on Project HERO case as fee-basis cases. How do you respond to these concerns?

Response: The administrative services provided by Humana Veterans under Project HERO are far superior to the administrative services performed by the individual VA Fee Offices. The VA maintains extensive records (spreadsheets, performance measured reports, etc.) for any contract purchased service, but they do not have similar requirements in traditional fee based care.

The administrative services provided by Humana Veterans are directly related to communication with the Veteran and the non-VA provider such as appointment setting, personal telephone contact with the Veteran, providing driving directions, and follow-up reminder calls. While there are a few VA Fee Offices that provide some appointment setting services, these functions are not normally performed by the VA in traditional fee care. Therefore, the perception that administrative costs are comparable between Project HERO and traditional fee care is misleading since Project HERO offers significantly more administrative services to Veterans. We have heard some VA Fee Offices state that it is easier for them to put an authorization in the mail to the Veteran than to use Project HERO. However, this traditional fee care procedure places the administrative burden on the Veteran. The Veteran must find a provider within the community, make sure that the provider can treat the specific condition, schedule the appointment, and request that the clinical information be returned to the VA. Project HERO ensures that the administrative burden rests on Humana Veterans instead of the individual Veteran. After an appointment with a network provider is established for the Veteran, the VA Fee Office is notified of the

date, time, and location of the Veteran's appointment. Humana Veterans stays in constant contact with the VA Fee Office to provide notification of additional appointments and to return clinical information from each visit the Veteran has with the network provider.

Another important aspect that causes administrative burden for the VAMCs is the way that they authorize care within the community. Authorizations are very limited in scope in a majority of cases. The network provider has very little latitude in terms of what he or she can do to actually treat the Veteran. The provider must evaluate and request that additional services be approved by the VA through Humana Veterans. This process of receiving approval from the VA for additional services can be long and arduous. If the VAMCs allowed the network providers to truly evaluate and treat the Veterans, the administrative burden of the additional services process would be significantly minimized.

The concern about how efficient Project HERO is compared to traditional fee care is dependent upon the individual VA Fee Office. The differences in management of individual VA Fee Offices are an ongoing issue within the VA since there are no standards for staffing, workflow, and processes. In addition, the arrangement of the VA Fee Office within the overall hierarchy of management can differ from VAMC to VAMC. The Fee Offices can be under the direction of the Business Office, Fiscal Office, or in the Clinical chain of command. All contracted services are perceived as an additional burden on those offices which lack appropriate staffing. The lack of performance standards within the VA Fee Offices makes it difficult, if not impossible, to perform a true comparison of Project HERO's efficiency versus traditional fee care. However, the significance of the enhanced administrative services that Veterans receive under Project HERO must be considered in the comparison with traditional fee care.

Question #3: The Subcommittee has also heard concerns from VA personnel about the lack of continuity of care. This is because VA primary care doctors cannot have direct contact with Humana providers, as the contractual relationship is between Humana and the non-VA provider. Is this a valid concern?

Response: This is not a valid concern. There is nothing that prevents VA primary care doctors from having direct contact with Humana Veterans' providers to discuss the care of Veterans. In fact, Project HERO enhances a VA primary care physician's ability to discuss a Veteran's care with the non-VA specialist since Humana Veterans communicates the details of the Veteran's appointment back to the referring VA Medical Center. These details include the identity of the specialist, as well as the date and time of the appointment.

Humana Veterans heard this concern from one of the VISNs in October 2009. Tim McClain, President and CEO of Humana Veterans, wrote a memo to all associates on October 13, 2009 in order to ensure that there was no confusion regarding our policy. The policy memo, copies of which were provided to the VA Program Office, reiterates our policy:

> "VA, our contract partner, has raised a concern regarding communications between the VA primary care physician and our HVHS network physicians. Apparently, some VA offices have the impression that HVHS discourages any direct communication between VA physicians and Humana Veterans network providers.
>
> In fact, HVHS encourages communication between our network physicians and VA physicians at any time, and especially when required by the standard of care. Our role is to administer and provide a health care network of professional providers and services, but never to proscribe or discourage communication between medical professionals.
>
> HVHS recognizes the absolute necessity of physician-to-physician communication as an important part of excellent health care services. We encourage and expect HVHS network physicians to communicate with VA physicians, and vice versa, whenever necessary in providing the most appropriate care to our Nation's Veterans.
>
> If there is ever any question on the appropriateness of physician-to-physician communications, please immediately raise the issue to your supervisor."

Continuity of care is significantly enhanced through Project HERO. First, Veterans are much more likely to get and keep timely appointments with outside specialists because of the facilitation of the appointing process under Project HERO. For example, servicemen and their families who receive care from outside providers under the Department of Defense's TRICARE program have an estimated No-Show

rate of 24 percent, which is three times higher than the 8 percent rate observed under Project HERO.

Second, Humana Veterans directly solicits VA medical leadership on their specific and special needs and then locates the providers to meet their needs. Examples include sleep labs with American Society of Sleep Medicine sleep specialists (Tampa) and Open MRIs of specified magnetic strength (Fayetteville).

Third, Humana Veterans invites VA physicians to participate in the quality oversight of network providers in order to extend the exacting standards of quality VAMC care into Project HERO. Not only is continuity of care maintained with Project HERO, more importantly, continuity of quality of care is also maintained.

Question #4: Subcommittee staff have been told that some non-VA providers are interested in participating in Project HERO but are unaware of how to be a part of the network. Related to this, we learned of some VISNs that had informal networks for specialty care but that Humana had a difficult time expanding its network in the same area. Has Humana largely addressed the network development concerns or does this continue to be a challenge?

Response: Humana Veterans Healthcare Services, Inc. is interested in obtaining as many high quality network providers as required to meet the needs of the VA and, in particular, to address the VA's rural health care access needs. Since future specific medical services and quantities, and the Veterans locations, are generally unknown to Humana Veterans until we receive an actual request from VA, we are constantly working to increase the network provider inventory. Humana Veterans network service representatives are responsible for recruitment of providers within their respective VISNs and catchments. Humana has toll free phone numbers available for providers to call a network service representative who can initiate the contracting process. We also have a Web site with a section dedicated specifically for providers. We have created several avenues for providers to find us and become part of the Humana Veterans network.

Some catchments within VISNs have informal specialty care networks. This was a difficult issue to address and overcome during the start up of the Project HERO contract, and it impacted all VISNs to some degree. In some cases, Humana Veterans was able to impart knowledge and understanding of our purpose and the intent of the Project HERO program which enabled us to successfully recruit the provider to our network. However, this was not achievable in every case. In many of the unsuccessful cases, the providers were reimbursed by the local VA at rates that exceeded the Project HERO contract rates. These providers lacked incentive to contract with Humana Veterans at the reimbursement rates we were able to offer. In addition, the VA in some instances informed providers that they would continue to use the provider directly and did not intend on using Humana Veterans under the Project HERO contract. Although we have addressed and surpassed this problem to a large degree, the problem still remains today especially in VISN 20. This competition by the VA for the same providers has caused our network to not be as robust as desired in some areas and specialties. It is counterproductive and inefficient for the VA to compete with Humana Veterans for the same providers for services offered under the VA's Project HERO contract.

Question #5: It is apparent that you see the promise and potential of Project HERO to improve care for our veterans. Do you believe that the Project HERO model is ripe for implementation in other VISNs? Or, do you believe that the model needs to be fine-tuned more before it is expanded to other VISNs? If further refinements are needed, what are some examples of these refinements?

Response: We strongly believe that the Project HERO model is ready for implementation in other VISNs because we agree with VA's testimony that Project HERO is meeting its objectives of improving quality oversight, access, accountability and care coordination. In its current form, it represents a vast improvement for Veterans over regular non-VA fee care. With that said, there certainly have been some valuable lessons learned from the first 2 years of this demonstration pilot that could be applied to further improve future implementations. Some examples of these refinements include the following:

- The HERO model should be the first choice when care is needed outside of VA. We recommend implementing a Right of First Refusal ("ROFR") process that would require VA to submit non-urgent referrals to the HERO contractor first. If the contractor is unable to provide the care according to contractual standards, then VA has the option to cancel the authorization. Timeliness standards can be built into the contract to ensure that this process does not delay care

for Veterans. This would ensure that the benefits of the HERO model are maximized and that the program is being used to the greatest extent possible.

- When implementing the model in a new geographic area, a longer implementation period is needed in order to fully establish and credential the provider network. Even in cases where there is already an established commercial network, time is needed to educate providers about VA requirements related to access and timeliness, and providers must agree to meet those standards. Additional credentialing may be needed in cases where VA requirements exceed commercial practices. We recommend an implementation period of no less than 6 to 9 months.
- The overall performance of the model could be improved if the contractor was provided reliable estimates of VA anticipated demand by specialty and location on some regular frequency (at least annually). This would allow VA to ensure that the needed services are on the contract, and it would allow the contractor to ensure that the appropriate provider network and administrative staffing are in place to meet the demand.
- The demonstration has shown that 100 percent standards are not achievable on certain metrics such as appointments in 30 days and return of clinical information in 30 days. We recommend setting those standards at very high but achievable levels, not to exceed similar standards for care rendered inside VA.
- We believe that there are other programs that could be piloted in future implementations that could further enhance the care coordination benefits of the model. Examples include
  - Improving the coordination and delivery of post-discharge care, such as home health care, by allowing the contractor to arrange and provide this care.
  - Piloting a utilization management program where the contractor assumes responsibility for applying standardized medical necessity criteria to all services requested through the HERO model.
  - Piloting disease management programs.

Unfortunately, the current HERO contract does not contain mechanisms to evaluate lessons learned and make adjustments in the middle of the current demonstration. However, we believe that these adjustments, along with any recommendations that VA offers, can certainly be applied to future implementations of the HERO model, and we see no reason that this model should not be made available to all Veterans with these improvements sooner rather than later.

Question #6: In your testimony you stated that you have seen a decline in the number of Project HERO referrals for the past 6 months when there should be about 10–12,000 in order to validate the HERO model. Can you explain what you mean and provide practical solutions on how to increase referrals?

Response: According to the report published by the Congressional Research Service on February 3, 2010, only 5.8 percent of outpatient visits to non-VA providers in the VISNs covered by Project HERO were sent to Project HERO. We believe it would be a better test of the program if VA took steps to ensure that HERO was the primary model in use in the four demonstration VISNs for providing care outside of VA. This would allow for a more meaningful comparison of results in these VISNs to VISNs that do not utilize the HERO model. As it stands today, there are competing models for providing non-VA fee care in each of the facilities participating in the HERO demonstration, and HERO is not the predominant model in use.

Low utilization also impacts the financial viability of the model for the contractor. Under the current contract, administrative fees are paid on a per-claim basis for services provided under Project HERO. More volume is needed to cover the contractor's administrative overhead of establishing and maintaining a robust provider network, operating a call center, etc.

A practical solution to increase referrals is the ROFR process described in our response to question #5. This approach would maximize the benefits of the HERO model while recognizing that VA has to be able to make other arrangements for Veterans' care in those rare cases where it cannot be provided under HERO according to the terms of the contract.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
February 16, 2010

Mr. P.T. Henry
Senior Vice President, Federal Government Programs
Delta Dental of California
11155 International Drive
Rancho Cordova, CA 95670

Dear Mr. Henry:

Thank you for your testimony at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Review of VA Contract Health Care: Project HERO" that took place on February 3, 2010.

Please provide answers to the following questions by March 30, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Does Delta Dental have the capacity to meet additional Project HERO authorizations beyond what you currently handle? If so, how many more authorizations can the current Delta Dental system handle?
2. You identified specific areas for procedural improvements that will enhance the overall contribution of the dental portion of Project HERO to the care provided to our veterans. Specifically, you cited the need to empower the Chief Business Office to manage the administration of the program and to enhance the standardization of policies and procedures across VISNs and medical centers.
   a. Do you believe that the dental portion of Project HERO has accomplished this so that there are standardized policies and procedures across the four VISNs and their medical centers?
   b. If so, what are some lessons to be learned to help enhance the standardization of policies and procedures if Project HERO were implemented in additional VISNs?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by March 30, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman, Subcommittee on Health, House Committee on Veterans' Affairs "Review of VA Contract Health Care: Project HERO"

February 3, 2010

Question #1: Does Delta Dental have the capacity to meet additional Project HERO authorizations beyond what you currently handle? If so, how many more authorizations can the current Delta Dental system handle?

Answer: The ability for Delta Dental to handle additional authorizations is not limited by our existing systems. Our ability to accept additional authorizations is, however, limited by the administrative costs associated with processing each authorization in accordance with Project HERO's requirements. Unanticipated challenges in contacting veterans to schedule care coupled with burdensome authorization processes, and case tracking and reporting requirements not envisioned in the program solicitation have proven to be labor intensive, expensive components of the program. A viable expansion of the current contract to additional VISNs would require either an increase in the Value Add Fee to reflect actual costs, or program revisions to streamline the administrative activities. (Note: Value Add Fee is the fee paid to the contractor intended to cover administrative costs.)

Question #2: You identified specific areas for procedural improvements that will enhance the overall contribution of the dental portion of Project HERO to the care provided to our veterans. Specifically, you cited the need to empower the Chief Busi-

ness Office to manage the administration of the program and to enhance the standardization of policies and procedures across VISNs and medical centers.

a. Do you believe that the dental portion of Project HERO has accomplished this so that there are standardized policies and procedures across the four VISNs and medical centers?
b. If so, what are some lessons to be learned to help enhance the standardization of policies and procedures if Project HERO were implemented in additional VISNs?

Answer a: No. Despite the efforts of the Chief of the Business Office and the Program Office to standardize policies and procedures across the four VISNs and medical centers, the policies and procedures governing the dental portion of Project HERO remain largely the lowest common denominator to which all 32 dental clinics will agree and adhere. The institutionalized and well-intentioned autonomy with which individual clinics operate, if left unchecked, will preclude Project HERO, and the Department of Veterans Affairs, from leveraging the advantages provided by private sector network-based care.

Answer b: Based on our experience, we would suggest that, prior to implementing Project HERO in additional VISNs, consideration be given to certain program modifications intended to:

1. Streamline patient contact and appointing by empowering the veteran, when feasible, to take a more active role in the process and requiring the veteran make first contact with the Project HERO contractor and encouraging the veteran to keep scheduled appointments;
2. Streamline authorization processing to recognize the quality and professionalism of credentialed network dentists and reduce unnecessary delays in providing care. This could be accompanied by the application of performance standards more in accordance with private sector network-based care;
3. Simplify and centralize the funding and billing processes;
4. Standardize authorization forms and associated reports; and
5. Require clinics to give priority to Project HERO when referring patients to Fee Care to facilitate VA's ability to link program objectives to cost effective management.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
February 16, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Gary M. Baker, Chief Business Officer for the Veterans Health Administration, at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health oversight hearing on "Review of VA Contract Health Care: Project HERO" that took place on February 3, 2010.

Please provide answers to the following questions by March 30, 2010, to Jeff Burdette, Legislative Assistant to the Subcommittee on Health.

1. Mr. Baker's testimony noted that costs for Project HERO are generally comparable to VA costs for other non-VA fee care. Is it possible to compare the cost per referral for Project HERO versus fee-basis care? What other cost comparison data are available?
2. Please list the types of outpatient services that the four VISNs have most often referred to Project HERO. How does this compare to the list of outpatient care services that the VA most commonly refers to the fee-basis care program?
3. What guidance did the central VA office provide to the four Project HERO VISNs on the criteria that should be used for making referrals to Project HERO versus fee-basis care? In addition, please explain the criteria that the four VISNs use in determining whether the referral goes to Project HERO or fee-basis care.

4. Humana testified that it is difficult to run a demonstration project when there is a competing process in the same fee office. To this end, Humana suggested that Project HERO become a first and preferred option in at least one VISN. Do you believe that a valid and independent impact evaluation cannot be conducted unless VA changes the implementation of Project HERO as suggested by Humana?
5. Several witnesses provided testimony pointing to the need for an independent evaluation of the Project HERO demonstration. Please walk us through the VA's evaluation plans. If the plan does not include a rigorous evaluation comparing a control and experimental group, how will the VA properly advise on the future of Project HERO?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by March 30, 2010.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael H. Michaud, Chairman, Subcommittee on Health, House Committee on Veterans' Affairs "Review of VA Contract Health Care: Project HERO"

February 3, 2010

Question 1: Mr. Baker's testimony noted that costs of Project HERO are generally comparable to VA costs for other non-VA care. Is it possible to compare the cost per referral for Project Hero versus fee-basis care? What cost comparison data are available?

Response: The Chief Business Office conducts detailed analyses concerning the cost of care provided under the HERO contract compared with the cost of care purchased under the traditional Fee Basis Program. These analyses use industry standard comparisons of specific services purchased. The assessment of costs by referral does not provide enough information to allow a complete understanding of the variation. Referrals may be for one or many services, which impacts the usefulness of any analysis. The analyses conducted show specific cost data, such as costs of a chest x-ray purchased under the HERO contracts compared with that same chest x-ray purchased under the traditional Fee Basis Program.

Question 2: Please list the types of outpatient services that the four VISNs have most often referred to Project HERO. How does this compare to the list of outpatient care services that VA most commonly refers to the Fee-basis care program?

Response: The outpatient services most often referred to Project HERO and the Fee-basis care program in Veterans Integrated Services Network (VISNs) 8, 16, 20, and 23 are detailed in the following charts. The count in the far right column refers to the number of claim line items authorized from demonstration inception through fiscal year 2009. All data is based on transaction data.

	Project HERO VISN 8			**Other Fee VISN 8**	
Rank	**CCS Description**	**Procedure Count**	**Rank**	**CCS Description**	**Procedure Count**
1	Therapeutic radiology	23,292	**1**	Home Health Services	114,733
2	Physical therapy exercises, manipulation, and other procedures	20,763	**2**	Physical therapy exercises, manipulation, and other procedures	109,657
3	Dental Services	12,695	**3**	Ophthalmologic and otologic diagnosis and treatment	76,040
4	Other diagnostic procedures (interview, evaluation, consultation)	9,560	**4**	Therapeutic radiology	75,667
5	Hemodialysis	5,630	**5**	Other diagnostic procedures (interview, evaluation, consultation)	62,292

	Project HERO VISN 8		Other Fee VISN 8		
Rank	**CCS Description**	**Procedure Count**	**Rank**	**CCS Description**	**Procedure Count**
6	Other CT scan	3,256	**6**	Laboratory—Chemistry and Hematology	57,219
7	Excision of skin lesion	2,806	**7**	DME and supplies	51,207
8	Other diagnostic nervous system procedures	1,910	**8**	Hemodialysis	49,951
9	Pathology	1,505	**9**	Psychological and psychiatric evaluation and therapy	43,876
10	Other non-OR therapeutic procedures on skin and breast	1,399	**10**	Other therapeutic procedures	33,557

	Project HERO VISN 16		Other Fee VISN 16		
Rank	**CCS Description**	**Procedure Count**	**Rank**	**CCS Description**	**Procedure Count**
1	Other diagnostic procedures (interview, evaluation, consultation)	19,964	**1**	Physical therapy exercises, manipulation, and other procedures	143,547
2	Dental Services	18,751	**2**	Laboratory—Chemistry and Hematology	104,078
3	Colonoscopy and biopsy	8,575	**3**	Home Health Services	89,288
4	Physical therapy exercises, manipulation, and other procedures	8,149	**4**	Therapeutic radiology	83,518
5	Ophthalmologic and otologic diagnosis and treatment	7,108	**5**	Peritoneal dialysis	74,885
6	Other diagnostic radiology and related techniques	5,492	**6**	Other diagnostic procedures (interview, evaluation, consultation)	62,746
7	Therapeutic radiology	4,888	**7**	Dental Services	33,218
8	Pathology	4,164	**8**	Other diagnostic radiology and related techniques	27,427
9	Laboratory—Chemistry and Hematology	3,613	**9**	Hemodialysis	27,079
10	Magnetic resonance imaging	3,491	**10**	Other therapeutic procedures	25, 248

	Project HERO VISN 20		Other Fee VISN 20		
Rank	**CCS Description**	**Procedure Count**	**Rank**	**CCS Description**	**Procedure Count**
1	Dental Services	6,649	**1**	Physical therapy exercises, manipulation, and other procedures	74,266
2	Other diagnostic procedures (interview, evaluation, consultation)	4,919	**2**	Other diagnostic procedures (interview, evaluation, consultation)	49,566
3	Physical therapy exercises, manipulation, and other procedures	3,351	**3**	Laboratory—Chemistry and Hematology	49,313
4	Magnetic resonance imaging	1,644	**4**	Psychological and psychiatric evaluation and therapy	34,397
5	Other diagnostic radiology and related techniques	1,519	**5**	Therapeutic radiology	32,985
6	Mammography	894	**6**	Dental Services	25,094
7	Therapeutic radiology	884	**7**	DME and supplies	24,602
8	Colonoscopy and biopsy	808	**8**	Other diagnostic radiology and related techniques	24,016

	Project HERO VISN 20			Other Fee VISN 20	
Rank	CCS Description	Procedure Count	Rank	CCS Description	Procedure Count
9	Ophthalmologic and otologic diagnosis and treatment	704	**9**	Home Health Services	21,520
10	CT scan abdomen	657	**10**	Ophthalmologic and otologic diagnosis and treatment	14,085

	Project HERO VISN 23			Other Fee VISN 23	
Rank	CCS Description	Procedure Count	Rank	CCS Description	Procedure Count
1	Dental Services	18,025	**1**	Physical therapy exercises, manipulation, and other procedures	143,056
2	Physical therapy exercises, manipulation, and other procedures	11,002	**2**	Laboratory—Chemistry and Hematology	59,871
3	Other diagnostic procedures (interview, evaluation, consultation)	5,719	**3**	Other diagnostic procedures (interview, evaluation, consultation)	55,674
4	Ophthalmologic and otologic diagnosis and treatment	5,522	**4**	Therapeutic radiology	38,909
5	Hemodialysis	2,547	**5**	Peritoneal dialysis	36,446
6	Hearing devices and audiology supplies	2,057	**6**	DME and supplies	32,642
7	Diagnostic physical therapy	935	**7**	Home Health Services	27,510
8	Laboratory—Chemistry and Hematology	896	**8**	Ophthalmologic and otologic diagnosis and treatment	25,571
9	Pathology	814	**9**	Dental Services	25,033
10	Other non-OR therapeutic procedures on musculoskeletal system	803	**10**	Other diagnostic radiology and related techniques	23,727

Question 3: What guidance did the central office provide to the four Project HERO VISNs on the criteria that should be used for making referrals to Project HERO versus Fee-basis care? In addition, please explain the criteria that the four VISNs use in determining whether the referral goes to Project HERO or Fee-basis care.

Response: In general, guidance on the use of Project HERO referrals as well as other Fee referrals is outlined below. It is a hierarchical process centered around the clinical needs of the Veteran. Key activities in the process include:

1. Assessing the clinical status of the patient (e.g. is the Veteran stable enough to travel if necessary);
2. Assessing VA internal capacity (e.g. can we refer to another VA);
3. Assessing other agreements in place such as University affiliation agreements, DoD/Sharing Agreements etc.; and
4. If the above options exist, does Project HERO have network capacity; if yes, refer to Project HERO provider.

Question 4: Humana testified that it is difficult to run a demonstration project when there is a competing process in the same Fee office. To this end, Humana suggested that Project HERO become a first and preferred option in at least one VISN. Do you believe that a valid and independent impact evaluation cannot be conducted unless VA changes the implementation of Project HERO as suggested by Humana?

Response: While VA understands the Humana Veterans Healthcare Services (HVHS) desire to consider a mandate, our experience has shown that the capacity is not available for 100 percent of all cases that require services outside VA. VA has seen significant increases in the use of the contracts, with some sites at greater than 30 percent of their referrals using HERO.

Question 5: Several witnesses provided testimony pointing to the need for an independent evaluation of the Project HERO demonstration. Please walk us through the VA's evaluation plans. If the plan does not include a rigorous evaluation comparing a control and experimental group, how will the VA properly advise on the future of Project HERO?

Response: VA has conducted one independent analysis of the project which identified additional lessons learned and provided suggestions for consideration as the Chief Business Office decides how to move forward with future contracts. Significant results are included in the listing below:

- The contracts are cumbersome and not easy to change or adapt to changing VA and Veteran needs.
- The inclusion of only some medical specialty services rather than all inpatient and outpatient services greatly reduces the contracts ability to meet all VA purchased care needs.
- The pricing structure is difficult to understand and requires more clarity and definition for all parties involved in serving and using the contracts.
- The administrative fee (value added fee) approach does not work well or fit industry standards for service fees.
- The contract does not have distance or time travel standards defined.
- The VA does not have an optimal way to determine quality of providers in the contracted networks.
- There is a lack of standard processes within the VA that create an inefficient model for the contracted networks to work within.
- Stronger quality reporting and monitoring processes are needed to meet VA provider expectations.
- A perception exists that VA providers cannot communicate directly with the contracted network providers. *(additional information contained in clarifications section of attached summary of external assessment report)*
- Because the contracts are not "mandatory" use contracts it has been difficult to reach a volume of care purchased through the contracts to perform as strong of an evaluation as could be with larger volumes.
- The inability to accurately estimate volumes of care that will be purchased creates a difficult setting for the contracted networks to know how many specific provider types are needed in any given market.
- The perception of cost effectiveness and desire to pay less than market rates or what other Fee mechanisms for purchasing care has cost historically could be limiting the ability of the contracted networks to obtain more providers willing to serve our Veterans.
- There is a lack of industry standard claim auditing procedures in place. *(additional information contained in clarifications section of attached summary of external assessment report)*

We currently are in the process of assessing future options, using a lessons learned survey to begin this process. We intend to use the results of the lessons learned survey to begin an additional independent evaluation of the pilot. Both the prior evaluation (completed by Corrigo—attached) as well as our future evaluations will be comparing the Project HERO results with our control group (traditional Fee Basis). Throughout our evaluations we have used this control group to assess impacts of change as well as determine future options for improving health care purchasing. Our next independent evaluation will assist VA in understanding the full results of the demonstration and how these results will inform future health care purchasing processes. As the demonstration contract has two remaining years, we intend to initiate this external review in Q1, FY11.