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HEARING ON VA CONTRACTS FOR HEALTH SERVICES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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SEPTEMBER 30, 2009

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WITNESSES

HEARING ON VA CONTRACTS FOR HEALTH SERVICES

WEDNESDAY, SEPTEMBER 30, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Tester, Begich, Burris, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. Good morning. Please be seated. The hearing of the Senate Committee on Veterans' Affairs on VA Contracts for Health Services will come to order.

This hearing will explore how VA purchases health care services. The Committee is interested in gaining a better sense of the process by which services are purchased and how VA oversees and manages those outside services.

While VA has authority to buy services for veterans in the community through various means, it is not clear if VA compares the cost of providing these services in-house to the costs of outsourcing. This raises a question as to whether VA gets value for the more than $3 billion spent annually on purchased care.

There are also concerns about how the VA monitors the quality of contract services to ensure that veterans are receiving timely and appropriate care. Whether contract care is obtained through a national contract with a large HMO, through a local contract for care at a community clinic, or for compensation and pension exams, VA remains responsible for insuring that the care or services are of high quality. This includes making sure that VA and contract providers share accurate and complete medical information.

Another area of concern is the extent to which individual VA hospitals and their networks have contracts for care which are unknown to managers here in DC. In an effort to increase accountability and oversight of contract services, VA recently restructured the contracting process to move contracting authority from the local level to more centralized points. The Committee hopes to learn today about how this reorganization will help VA ensure that contractors supply quality services at a fair price to the benefit of the VA and the taxpayers.

It is also important to focus on what mechanisms are in place so that VA contracts for services only if it does not make sense for VA

to supply the services directly. Today's hearing is part of the Committee's oversight of how VA provides health services outside of VA. No matter the setting, the Nation's veterans deserve timely access to the highest quality services available.

At this time I would like to welcome the witnesses on our first panel. Joseph Williams, Acting Deputy Under Secretary for Health, Operations and Management of the Veterans' Health Administration, will lead the discussion on VA contracts for health services. He is accompanied by Frederick Downs, who is Chief of Procurement and Logistics Officer at VHA; Gary Baker, Chief Business Officer at VHA; Bradley Mayes, Director, Compensation and Pension Service at VBA; and Jan Frye, Deputy Assistant Secretary for Acquisition and Logistics.

I thank all of you for being here this morning and want you to know that your full testimony will appear in the record.

Before we begin with your testimonies, I want to call on Senator Tester for his opening remarks.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman.

I guess I made it just in time. I wish I could have heard your comments, yet I want to thank you very much for having this hearing on this important issue. And, as always, I want to thank the folks who came to testify and give their perspective for being here also. I appreciate it very much.

I start from the same perspective as the American Legion when it comes to the VA health system. The Legion called it a system worth saving and I could not agree more.

It is clear to me that the Legion speaks for an awful lot of veterans who want to see the system strengthened, not dismantled.

But I recognize that there are limits to what the VA can do. We see it all over rural and frontier America; contracting of mental health services in Montana is an absolute necessity.

There is only one mental health professional in the entire State east of Billings, and Billings is not the eastern edge of Montana. Contracting of speciality care and emergency services in rural and frontier areas makes sense as well because we simply do not have the providers.

It does not do anyone any good to put the VA and the private sector in direct competition for the doctors and nurses and other medical professionals that are increasingly in short supply in rural America.

Contracting out can sometimes simply be the right thing to do for the veteran. You do not put a veteran from Billings with a back injury on an 8-hour bus ride to Denver for surgery; at least I would hope you better not. You find a way to get him surgery in his own neighborhood.

But contracting is not a cure-all even in rural America. I know that the VA in Montana has had to cancel a couple of CBOC contracts for poor performance or failure to adapt to the VA electronic medical records, which are the linchpin of VA's health care system.

I am particularly concerned about reports regarding VA's overpayment of contracted services for compensation and pension

exams. I see that private companies are doing more and more of these exams at an average cost of $850 per veteran. That might make some sense and it might not. I guess that is what this hearing is about.

I am very worried that we do not have the data we need to understand whether privately performed C&P exams actually lead to more efficient C&P claims processing. I hope we can get information on that during this hearing.

We are in tight budget times so let us make sure we are not tolerating waste, fraud, or abuse in the contracting process before we think about trying to raise copayments and fees on veterans, as the Bush administration had proposed, or before we think about forcing VA health costs onto veterans private insurance, as the Obama Administration proposed.

Finally, Mr. Chairman, I would just add that contracting out medical services is hardly a cure-all for the private providers. Many of these folks in my State wait for reimbursement well beyond the VA's goal of 30 days after the claim is submitted. Many of these facilities are small critical access hospitals that have little or no margin for error in their cash-flow.

So, I want to commend you, Mr. Chairman, for holding this hearing. I look forward to hearing from the witnesses and the questions thereafter.

Thank you very much.

Chairman AKAKA. Thank you very much, Senator Tester.

At this time I would like to call on Mr. Williams for your statement.

STATEMENT OF JOSEPH A. WILLIAMS, JR., RN, BSN, MPM, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY FREDERICK DOWNS, JR., CHIEF PROCUREMENT AND LOGISTICS OFFICER, VETERANS HEALTH ADMINISTRATION; GARY BAKER, CHIEF BUSINESS OFFICER, VETERANS HEALTH ADMINISTRATION; BRADLEY MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION; AND JAN FRYE, DEPUTY ASSISTANT SECRETARY FOR ACQUISITION AND LOGISTICS

Mr. WILLIAMS. Mr. Chairman, Ranking Member, Members of the Committee. Thank you for the opportunity for us to discuss the Veterans' Affairs oversight of health care contracting.

The VA provides care to veterans directly in a VA medical center or indirectly through either fee-basis care or through contracts with local providers. This strategic mix of in-house and external care provides veterans with a full continuum of health care services.

VA medical center directors determine when additional resources are required. It is VHA policy to hire clinical staff whenever feasible. But when this is not possible or inadvisable, the medical center director must first consider sending patients to another VA medical center. If contracting of services are required, a competitive bid is the first option considered.

There are two principal avenues of contracting for health care services: conventional commercial providers and academic affili-

ates. VA academic affiliates provide a large portion of contract care and critical care.

In either approach, VA is ultimately responsible for the quality of care delivered in its facilities for veterans. VA exercises this responsibility through credentialing and privileging, quality and patient safety monitoring, and specific quality of care positions within a contract itself.

All applicable VA quality and patient safety standards must be met for medical services provided under contract in a VA facility. Ensuring quality standards for VA-contracted care when services are provided outside of the VA facility is more complex, but VA-contracted care includes language that allows for industry standards of accreditation, certification requirements, clinical reporting, and oversight. VA also includes clauses in their contract that allows it to negotiate additional terms as the new clinical requirements are instituted within the department.

VA understands the importance of closely managing its contracts and has initiated multiple efforts to address this. Project HERO is a cornerstone of those efforts. Project HERO, which is available in four VISNs, four of our networks, is a contracting pilot to increase quality oversight and reduce the cost of purchased care.

In Project HERO, VA contracts with Humana Veterans' Health Care Services and Delta Dental Federal Services to provide veterans with prescreened networks of doctors and dentists who meet VA quality standards. This is done at negotiated rates.

In fact, 89 percent of Project HERO contact medical prices with HVHS are below the Medicare rates and contracted rates with Delta Dental are less than 80 percent of the National Dentistry Advisory Services Comprehensive Fee for dental services.

Project HERO contracts require that Humana and Delta Dental meet VA standards for credentialing and privileging. Timely reporting of access to care, timely return of clinical information to VA, patient safety and patient satisfaction, and quality programs including peer review are all components of this process.

There are no known instances where VA medical centers have reduced staff following the introduction of Project HERO contracts.

While Project HERO is only in the second year of a 5-year pilot, VA has found that patient satisfaction is comparable to VA and robust quality programs including peer review with VA participation while meeting Joint Commission and other industry standards.

While VHA recognizes the continuous need for improvement, this project has validated our ability to resolve key oversight issues.

Mr. Chairman, you also asked us to discuss contracting for compensation and pension examinations. Medical examination reports are an important part of VA's disability claim process.

Although the majority of these examinations are conducted by VHA, C&P Service has the authority to contract with the outside for medical providers in an examination process.

During fiscal year 2008, medical disability examination contractors conducted approximately 24 percent of all the compensation and pension exams. C&P Service has contracted with two medical disability examination providers: QTC Medical Services and MES Solutions.

QTC was first awarded a contract in 1998. QTC successfully competed for rebid of a contract in 2003. During fiscal year 2008 QTC completed 117,089 examinations.

Six VA regional offices order at least some of their examinations from MES. This contractor currently performs approximately 1,550 examinations per month.

C&P Service oversees both of these contracts. The oversight involves three standards: performance; quality and timeliness; and customer service, which are evaluated quarterly.

Mr. Chairman, VA prides itself on providing consistent, high-quality care to veterans; and contracting and fee-basis arrangements and agreements are important components of the VA's national system of health care.

We recognize the importance of our responsibilities in the oversight of care purchased outside our facilities or provided by contractors within our facilities. We will continue to work to develop initiatives intended to improve the oversight of these agreements.

Thank you for this opportunity. My colleagues and I are prepared to answer your questions.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF JOSEPH A. WILLIAMS, JR., RN, BSN, MPM, ACTING DEPUTY UNDER SECRETARY FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, Ranking Member, and Members of the Committee: Thank you for providing me this opportunity to discuss the Department of Veterans Affairs' (VA) oversight of health care organizations contracting with VA to provide health services to Veterans. I am accompanied today by Jan Frye, Deputy Assistant Secretary for Acquisition and Logistics, Department of Veterans Affairs; Fred Downs, Chief Procurement and Logistics Officer, Veterans Health Administration; Patricia Gheen, Deputy Chief Business Officer for Purchased Care, Chief Business Office, Veterans Health Administration; and Bradley Mayes, Director of the Compensation and Pension Service, Veterans Benefits Administration.

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

OVERSIGHT OF HEALTH CARE CONTRACTS

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

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

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

There are two principal avenues to contract for health care services: conventional commercial providers and academic affiliates. VA's academic affiliates (schools of medicine, academic medical centers and their associated clinical practices) provide a large proportion of contracted clinical care both within and outside of VA.

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

QUALITY MANAGEMENT FOR CONTRACTED CARE

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

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

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

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

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

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

PROJECT ON HEALTHCARE EFFECTIVENESS THROUGH RESOURCE OPTIMIZATION (PROJECT HERO)

Given our desire for patient-centered care and recognizing that it may not always be able to provide Veterans care within our facilities, VA has a continued need for non-VA services. This purchasing of health care services represents a key component in our health care delivery continuum. VA understands the importance of closely managing the services purchased and has initiated multiple efforts around improving that management. Project HERO is a cornerstone of those efforts.

House Report 109–305, the conference report to accompany Public Law 109–114, provided that VA establish at least three managed care demonstration programs to satisfy a set of health care objectives related to arranging and managing care. The conferees supported VA's expeditious implementation of care management strategies that have proven valuable in the broader public and private sectors, and to ensure care purchased for enrollees from community providers is cost-effective and complementary to the larger VA health care system. The conferees encouraged VA to

collaborate with industry, academia, and other organizations to incorporate a variety of public-private partnerships.

Project HERO is in year two of a proposed five-year contracting pilot to increase the quality oversight and decrease the cost of purchased (fee) care. It is currently available in four Veterans Integrated Service Networks (VISN): VA Sunshine Healthcare Network (VISN 8), South Central VA Health Care Network (VISN 16), Northwest Network (VISN 20) and VA Midwest Health Care Network (VISN 23). These VISNs have historically had high expenditures for non-VA purchased care (fee care) and substantial Veteran enrollee populations. When VA cannot readily provide the care Veterans need internally, VA medical centers utilize the traditional fee basis program or, in selected VISNs, Project HERO.

Project HERO is one of our most comprehensive pilot programs intended to improve the management and oversight of the purchase of non-VA health care services. It represents a significant and proactive approach to assessing timeliness, quality, and clinical information sharing for purchased care services, resolving potential deficiencies in this area. In Project HERO, VA contracts with Humana Veterans Healthcare Services (HVHS) and Delta Dental Federal Services to provide Veterans with pre-screened networks of doctors and dentists who meet VA quality standards at negotiated contract rates.

Project HERO is predominantly an outpatient program for specialty services such as dental, ophthalmology, physical therapy, and other services not always available in VA. For every patient, VA medical centers determine and authorize the specific services and treatments to Project HERO contracted network doctors and dentists.

Project HERO's demonstration objectives have been shared with a number of key stakeholders, including Veterans Service Organizations, the American Federation of Government Employees, academic affiliates, and industry. The VHA Project HERO Program Management Office presented the following objectives to the House Appropriations Committee and House Veterans' Affairs Committee in the second quarter of 2006:

- Provide as much care for Veterans within VHA as practical;
- Refer Veterans efficiently to high-quality community-based care when necessary;
- Improve the exchange of medical information between VA and non-VA providers;
- Foster high-quality care and patient safety;
- Control operating costs;
- Increase Veteran satisfaction;
- Secure accountable evaluation of demonstration; and
- Sustain partnerships with university Affiliates.

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

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

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

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

Humana Veterans Healthcare Services utilizes the Agency for Health Research and Quality patient safety indicators as well as complaints, referrals and as sources for initiating peer review. The Project HERO PMO monitors contract performance, audits credentialing and accreditation, and evaluates HVHS and Delta Dental performance compared to VA Survey of Healthcare Experiences of Patients (SHEP),

Joint Commission measures, and proxy measures based on HEDIS measures. This analysis indicates that Project HERO facilities are equal to or better than the national average for all non-VA hospitals that report to the Joint Commission.

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

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

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

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

COMPENSATION AND PENSION SERVICE OVERSIGHT OF CONTRACT MEDICAL EXAMINATIONS BACKGROUND

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

MDE Contractors

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

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

Public Law 108–183 provided VA with supplemental contracting authority that differed from the existing authority in the following ways: (1) funding for examinations under this authority utilizes discretionary funds, (2) the number of locations at which VA may use contract examiners is not limited, and (3) the authority currently will expire on December 31, 2010. Pub. L. 110–389, section 105 extends the authority of Pub. L. 108–183 until December 31, 2010. MES has been awarded the contract under this authority and began performing examinations in August 2008.

Six VA regional offices order at least some of their examinations from MES. This contractor currently performs approximately 1,550 examinations per month.

VA Oversight

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

There are three primary performance measures for assessing contractors:

- The QTC quality performance standard requires at least a 92 percent accuracy rate. Quarterly, 384 examination reports are randomly selected from the ten VA regional offices and their BDD sites. Reviews are conducted by the Medical Director of Contract Examinations and C&P Service rating experts for accuracy.
- The timeliness performance standard is 38 days measured from the time the contractor receives the examination request until the final examination report is entered into the electronic system for retrieval.
- The customer satisfaction performance standard is based on a survey questionnaire given to the Veteran as part of the examination. An independent contractor distributes, receives, and analyzes the results. The questionnaire asks for information on the following: medical office wait time; performance of medical administrative and support staff; reasonableness of medical office visit time and place; cleanliness of the medical office; performance and responsiveness of the medical examiner; and the overall satisfaction with the medical office visit. Answers provided by Veterans are converted to an overall percentage rate. A customer satisfaction standard of at least 92 percent is required.

CONCLUSION

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

Chairman AKAKA. Thank you very much for your testimony, Mr. Williams.

I would like to, before asking questions, ask Senator Begich for any opening remarks he may have.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Mr. Chairman, I do not have any. I will look forward to the questions because Senator Tester told me to say that.

[Laughter.]

Chairman AKAKA. Thank you very much, Senator Begich.

Mr. Williams, I thank you for bringing others to accompany you here at this hearing. I just want to mention to you to feel free to call on them as we move along with the questions, though I will pose the questions to you.

Mr. Williams, what is the total amount that the VA spends on outside providers including all health services?

Mr. WILLIAMS. Mr. Chairman, I would like to defer that to Mr. Baker.

Mr. BAKER. The answer is in 2008 we spent approximately $3 billion on contracted services and fee services, and this year we estimate that we will spend approximately $3.8 billion.

Chairman AKAKA. Can you describe how VA is able to monitor such large spending?

Mr. BAKER. We have standard financial controls in place. Over the last 2½ years, we have developed a financial data warehouse of information at our Veterans' Service Center. We use that information to provide detailed financial information concerning the use of fee-basis and contracted services available with information at the medical center level, at the division level, and at the national level. This information is not at those levels and used for internal review and for financial reporting across the organization, sir.

Chairman AKAKA. Does VA have access to and routinely review quality assurance information by contractors?

Mr. WILLIAMS. Yes, sir, we do; and we do that through a number of means. Mr. Downs would be able to share with you some of the aspects of contract oversight.

Mr. DOWNS. The contracting officer and the COTR, their responsibility is to work with the program as they build those quality measures into the contract for performance standards and metrics.

The COTR then monitors that contract on a regular basis, reports back to the contracting officer if there are any difficulties, in which case then the contracting officer then works with the vendor to correct those. We have regular reviews that are conducted internally to ensure that the contractor is performing up to the metrics he or she is supposed to.

We then also have outside reviewers. The OIG and GAO will come by and review those contracts. They have a CAP review that they conduct now on a regular bases, certainly among the CBOCs. We have those internal reviews that we are using. Yes, sir.

Chairman AKAKA. Recently, Mr. Williams, a review by the Inspector General found that a contractor providing services at a community clinic, did not follow VA's credentialing and privileging policies. The question is: What will VA do to ensure that contract providers are following these policies?

Mr. WILLIAMS. Thank you, Mr. Chairman.

There are several actions that we have initiated. One is to ensure that the appropriate language is included in contracts going forward.

The second is the medical center, in addition to the COTR, has a responsibility to review this information and make sure it is incorporated into leadership discussions and appropriate actions are communicated up through the channels to be taken.

At various levels in the contracting process, we have individuals that also are reviewing the contracts against the deliverables of that contract and decisions will be made based upon those as to what training, education, or other actions that may be necessary are taken.

I will defer to Mr. Downs for any additional comments.

Chairman AKAKA. Mr. Williams, on overcharges for CBOC contract care, a recent report from the Inspector General found that

VA had been charged by a clinic contractor for over 4,000 veterans who are no longer enrolled in that VA clinic.

What did VA do to address that specific problem and what steps will the department take to prevent similar situations from occurring in the future?

Mr. WILLIAMS. Mr. Chairman, I would like to defer to Mr. Frye.

Chairman AKAKA. Mr. Frye.

Mr. FRYE. I have to admit that I am not familiar with the CBOC operation, and I just looked at that IG report yesterday.

Those contracts are put in place by Veterans Health Administration in the local contracting offices. Again, Mr. Downs has outlined the fact that he has contracting officer technical representatives looking at the performance of these contractors and they are the first line of defense. They are the eyes and ears of the contracting officer. If they see something awry with the performance of the contractor, they are to immediately bring that to the attention of the contracting officer—the government contracting officer—so that remedial action can take place.

Chairman AKAKA. Thank you.

Mr. BAKER. Mr. Chairman, if I might, in answer to your question, one of your concerns was do we preclude this from occurring going forward.

We do take these lessons learned from IG reports and outside reviews and share them across our networks with our network directors and facility directors. We have regular conference calls and we have summary reports of these type of reviews to make sure that information is shared so it can integrate and the lessons learned can be shared with our leadership. We make sure we do not repeat the same mistakes in the future.

Mr. WILLIAMS. Mr. Chairman, if I may, in addition, from an operations standpoint, we review the contracts. Every 2 weeks we look at all of the contracts from the beginning of the process through to the end of the process.

In addition to that, we have an advisory group that will review contracts and bring them to me directly at this point through the reorganization where we will review those contracts and determine what additional actions—be it training, education, or reconfiguration—that need to take place.

Chairman AKAKA. Thank you.

I would like to call on Senator Tester for his questions.

Senator TESTER. Thank you, Mr. Chairman.

We have learned from previous hearings that the disability exam can be quite complicated, especially when exams involve multiple body systems and a complex rating system.

Can you tell me how long it takes for a VA physician to learn how to conduct the exams?

Mr. WILLIAMS. Sir, I do not have that specific information with regard to the actual time it would take. I would add, though, that we have a time requirement relative to the completion of an examination—the actual completion of examination.

Senator TESTER. But I mean as far as what kind of regimen the VA physician has to go through in order to be competent when they step into the exam room.

Mr. WILLIAMS. Mr. Baker will address that.

Mr. BAKER. We do have a certification program that was begun approximately 1½ years ago for compensation and pension exam providers. It was designed through our compensation and pension exam program in Nashville.

Senator TESTER. Typically how long does it take for a physician to go through that program?

Mr. BAKER. It depends to a certain extent on the specialty. There is a general medical examination module, but there are modules I think for approximately 29 specialty type exams.

I do not have the specific amount of time that each of those modules is, but we will take that as a note for the record to provide to the Committee.

Senator TESTER. That would be good.

[The additional information requested during the hearing follows:]

TIME TO COMPLETE CPEP CERTIFICATION/TRAINING MODULES

In 2007, the Compensation and Pension Examination Project (CPEP) developed six web-based certification modules for Compensation and Pension (C&P) exams; the certification process began in 2008. These certification modules are designed to instruct providers on how to effectively conduct and document C&P exams for rating purposes. The intent is to provide a thorough understanding of the C&P process, terminology, types of requests and strategies for writing exam reports and opinions in order that providers can help ensure that Veterans receive timely, thorough and fair evaluations of their claimed conditions.

CPEP has produced a total of 19 training modules on performing and documenting C&P exams. There are six certification modules: General Certification, Musculoskeletal, Initial PTSD, Review PTSD, Initial Mental Disorders and Review Mental Disorders.

There are 13 other informational CPEP modules: Aid and Attendance, Cold Injury Exam, Diabetes Exam, Foot Exam, General Medical Exam, Genitourinary Exam, Hand, Fingers & Thumbs Exam, Heart Exam, Muscle Exam, Nerve/Neurology Exam, Prisoner of War Exam, Respiratory Exam and Skin & Scar Exam.

The intended audience for the modules is C&P examiners, physicians, physician assistants, psychiatrists, psychologists, nurses and nurse practitioners. The clinicians can receive Accreditation Council for Continuing Medical Education (ACCME) or American Nurses Credentialing Center (ANCC) continuing education credits for each of the modules.

TIME TO COMPLETE MODULES

The average time required to view each CPEP module and answer the accompanying questions is provided below, but the time may vary depending on the clinician.

- General Certification module: 1.5 hours
- Musculoskeletal Certification module: 1 hour
- Initial Mental Disorders Certification module: 1.5 hours
- Review Mental Disorders Certification module: 1 hour
- Initial PTSD Certification module: 2 hours
- Review PTSD Certification module: 1 hour
- Other informational training modules: 1 hour each

All C&P clinicians must complete the one and-a-half (1.5) hour General Certification module. Those performing musculoskeletal exams must complete that module also, for a total time of two and-a-half (2.5) hours. Mental health specialists performing only review mental health exams must complete the General Certification plus the two review mental health modules for a total time of three and-a-half (3.5) hours. Mental health specialists performing all four types of mental health exams must complete the General Certification plus all four mental health modules for a total time of seven hours.

TIME TO LEARN TO CONDUCT EXAMS
(REGIMEN TO BE COMPETENT WHEN CLINICIAN STEPS IN THE ROOM)

From the summary above, we know that it takes one and-a-half to seven hours to complete the CPEP certification process. Completing the appropriate CPEP certification modules should provide a clinician with the background and overview that he or she needs to perform a competent C&P disability exam and report.

However, expertise in the C&P process is something that takes time to acquire. Most clinicians are experienced in performing treating exams, but not C&P disability exams, which are unique medical-legal exams. Many new C&P clinicians will go through the certification process and then shadow another clinician for a week or so. New C&P clinicians often have their exam reports critiqued by more experienced C&P clinicians for several weeks or longer.

As clinicians take time to attend C&P conferences, review results from CPEP's quality reviews, discuss cases with colleagues, and gain experience in interviewing and examining Veterans specifically for C&P disability purposes, their expertise and skill as C&P clinicians increases.

Senator TESTER. You have 29 specialty exams. Does each veteran have 29 docs take a look at him?

Mr. BAKER. No. In terms of the rating requests that we receive from the Veterans Benefits Administration, there are approximately 29 templates for types of exams that are requested from them. I think 29 is the correct number. I may be off one or two.

Senator TESTER. Typically how many docs look at a vet when they do their exam?

Mr. BAKER. My understanding is that for recently discharged veterans, there are up to 11 disabilities that have been requested; and in general, they require two or three exams at least to complete the review of their body systems for the disability exams that have been requested.

Senator TESTER. Do you have any idea how long those exams take?

Mr. BAKER. I do not have that information, really.

Senator TESTER. That is fine. Does the VA train the contractor physicians in the same way they train the VA physicians?

Mr. BAKER. I cannot speak for QTC as to whether or not they use our training modules or not. Mr. Mayes may have the answer.

Mr. MAYES. We did not specifically train the contract exam providers but there are certain credentialing requirements that they have to have before they can conduct a C&P examination. All of the examiners or the contract providers that are conducting C&P exams are physicians.

The other point that I would make is that the criteria by which the exam is conducted is based on exam templates and exam worksheets. This is a collaboration between the Veterans Benefits Administration and the Veterans Health Administration.

We work with the medical experts to come up with the protocol for the C&P exams, such that it gives us an exam report and exam findings that allow us to match that up against the VA rating schedule.

Senator TESTER. So, what I am hearing you say—and you may correct me—the critical component of this is not necessarily the physician's level of expertise on how to conduct the exam, but rather the template?

Mr. MAYES. I would not characterize it exactly that way, Senator. I think it is critical that an examiner be properly credentialed, be familiar, and understand how to apply that.

Senator TESTER. When it comes to quality control, I am sure you do assessments on the docs that do these 29 different types of exams. Does the VA do quality control on those docs to make sure that there is a level of adequacy and accuracy there?

Mr. BAKER. The compensation and pension exam program that I mentioned in Nashville has a comprehensive quality assurance program for examinations conducted by VHA physicians. We do a sample review of exams from each medical center for all providers on a monthly basis and provide that information to VBA and internally to VHA.

[Additional information provided by VA follows:]

Question. How does VBA ensure that field stations send accurate examination requests to the contractors?

Response. The C&P Contract Management Staff reviews examination requests on a daily basis. If the examination request is incomplete, it is immediately sent back to the field station of jurisdiction for correction. The Contract Management staff is in contact with the examination coordinators at the regional offices daily to answer questions and provide guidance. The staff holds monthly conference calls with the examination coordinators to review any error trends and update them on changes.

Senator TESTER. What quality assurance process do you have for the QTC folks?

Mr. MAYES. There are three elements to the measurement of quality with respect to QTC and MES, the other contractor that provides exam services.

We measure the contractor on timeliness. We measure the contractor on quality. It is very similar to what we do under the VHA exams with respect to quality—do they comply with the criteria that is established for the exam report that then allows our rater to evaluate the veteran's disability claim. And then, also, we evaluate the provider on customer satisfaction.

[Additional information provided by VA follows:]

Question. How does VBA ensure that contractors properly complete examination requests?

Response. Both medical disability examination contractors are reviewed for compliance on exam quality (92% or better), exam timeliness (38 days to complete the request on average), and overall customer satisfaction (90% or better).

To measure compliance with examination quality, the C&P Contract Management Staff completes quality review on 530 completed examinations quarterly. These reviews are in addition to reviews completed by the contractors.

To measure examination timeliness, completed examinations are pulled from the contractor's computer system into VA's system on a nightly basis, and VA measures the number of days between the exam request and delivery.

Overall customer satisfaction is measured through a Customer Survey Card contract with AMTIS. AMTIS produces customer survey cards that are sent to the contractors for insertion in the Veteran's examination appointment letter. AMTIS compiles the card results and submits a report to the Contract Management staff on a monthly basis. The average return rate on the customer survey cards is 40 percent.

The Contract Management Staff also holds monthly conference calls with both contractors to discuss issues and provide guidance on any changing policies.

Senator TESTER. Do you compare the outcomes of the disability ratings between the contractors and the VA?

Mr. MAYES. For our purposes in making an entitlement determination, we are concerned that the output—the exam report—is adequate for us to evaluate the veteran's claim. To that extent, we have standards in place for quality and we are checking that both in VHA and with our contract providers.

Senator TESTER. I did not note it and you do not have to say it again. Are the outcomes of the disability ratings that are given by VA and QTC, are they tracked?

Mr. MAYES. Yes, Senator, they are tracked. The quality is tracked both for VHA exams, C&P exams, and contract-provided exams.

Senator TESTER. OK. My time is up. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.

Let me call on Senator Begich for your questions.

Senator BEGICH. Thank you very much, Mr. Chairman.

First, I have a more general question on HERO versus the traditional fee-basis program. I know you are 2½ years into the HERO program, and it seems to have—or at least in the process of having—some success.

What is the long-term outlook that you would see in the HERO program in the sense that it is on a 5-year demonstration project; so what is next?

Mr. WILLIAMS. Sir, Mr. Baker will answer that question.

Mr. BAKER. The HERO program, as you know, is a pilot program with a potential of 5 years. We are getting ready and, in fact, have exercised the third year of the contract, which will start actually tomorrow.

We believe that the HERO contract has given us a wonderful opportunity to learn some valuable lessons on our ability to have national- or regional-level contracts, the type of specifications we need for that contract, and how to interact with our partners in providing those services.

I would say that going forward I would not expect that if we were to recompete a HERO contract that it would be exactly the way that we specified in our original contract.

There are many lessons that we have learned from both sides of the equation, both from a VA perspective—in terms of specifying the pricing schedule, some of the criteria in terms of how we refer patients, and what our expectations are of the provider—and I am sure the provider side has some feelings on that as well.

We have used this as a test bed to learn lessons going forward and we expect to continue to do that through the life of the existing contract.

Senator BEGICH. Great. I just want a clarification on one point. I do not remember who said it, but on the amount of contracted services, you indicated $3 billion this year and next year $3.8 billion. When I look at the IG report, it talks about I think $1.6 billion. So, just help me understand.

Mr. BAKER. The IG report was on outpatient pre-authorized care only.

Senator BEGICH. So, a portion of the total——

Mr. BAKER. Right, a portion of the total. But, the question we were asked was about total cost of non-VA care, or purchased care, so the numbers I provided were for that amount.

Senator BEGICH. Great. I do not know who would answer this, maybe Mr. Williams. Do you agree with the IG report in their analysis of what they have calculated in overpayments and those kinds of issues?

Mr. WILLIAMS. I will defer to Mr. Baker.

Mr. BAKER. You are talking about the fee-basis IG report rather than the CBOC?

Senator BEGICH. Yes.

Mr. BAKER. In general we agree with the IG report. We think that there are some specific numbers, in terms of their 37 percent figure, that probably are an overstatement.

Senator BEGICH. How much overstatement would you say? I mean is it double what you think it is; because I am going to drive to the next question which is further discussion of the accountability measures that you have in place or will have in place.

So, is it a little bit over? 37 percent is a lot.

Mr. BAKER. We agree with that.

Senator BEGICH. Give me an idea of what you think.

Mr. BAKER. I cannot give you an exact number, but I can tell you a couple of factors that I think need to be taken into consideration.

One is that we have a mechanism where on our fee authorizations we specify a certain payment amount and that payment amount may not be in line with the 75th percentile that is our fee schedule.

The IG considered that as an error on our part, saying we should have paid on the 75th percentile. We actually have a General Counsel opinion that says that we were correct in using the authorized amount. So, that will have an impact of that number.

They also included any discrepancy between the paid amount and the amount that they calculated would be accurate, even if it was less than a dollar. The industry standard is that many of those would not have been counted.

So, we are doing a detailed review of their information. We expect the number will go down but it still will be a number that requires us to follow up with actions.

Senator BEGICH. Have you at any point in the last 3 or 4 years—I think this was a 4-year study—have any folks that you do business with been canceled in the sense of outpatient care?

In other words, because of double billing or inappropriate expenditures that appear for reimbursement? Have you ever canceled anybody? Have you ever said, you know what, you have an error rate that is too high, you are out? Have you ever done that?

Mr. BAKER. Not to my knowledge.

Senator BEGICH. OK. You can see where I am going here. It is great to have a report and let us say it is 15 percent, let us say it is half, say it is 18½ percent; it is still tens of millions of dollars.

And if the contractor continues to perform the service and all it amounts to is a lot of paper going back and forth but you do not actually lay down hard on them and say, you know what, we are not doing business with you anymore; that will send a message and create a ripple effect to people who inappropriately bill.

So, I guess I would urge you in your process of reevaluating your procedures that is part of it: that you make it clear that if you continually send poor records you are out, period.

Then the next question I would have is do you have any numbers that you can share with me or the Committee on how much you have recouped in any of the overbillings or accounting errors on the part of physicians or outpatient services?

Mr. BAKER. I think we have some apples and oranges that are being mixed here. In terms of the IG report and the 37 percent, the vast majority of that was a determination that we had inappropriately processed those bills internally, not that they had been billed incorrectly by the providers.

So, in terms of saying that because of the IG report we should have taken action against providers, I do not think that is the case.

Senator BEGICH. OK. My time is pretty much up. But when I read it, there is an amount overpaid—maybe it is defined differently, how you define it—and then there is underpaid.

So, are you telling me all the overpaid are just VA mistakes on the proper report paperwork and that everyone should have been paid?

Mr. BAKER. I am saying that in the IG report when they said there were overpayments, they are saying that VA inappropriately applied either its fee schedule or a Medicare schedule that should have applied for what was billed to us, and that was not a fault of the vendor but rather an internal fault of VA, and that we need to improve our procedures.

Senator BEGICH. Let me end there. So in no case, a vendor has received double payment for any services?

Mr. BAKER. No. There were some situations where VA should recoup and we are following up on those specific cases——

Senator BEGICH. That is the question.

Mr. BAKER [continuing]. As identified in the IG report and we will be requesting repayment to VA where that overpayment has occurred.

Senator BEGICH. I will end there. Thank you, Mr. Chairman. I am sorry I went over a little bit.

Chairman AKAKA. Thank you, Senator Begich.

Senator Burr, your opening statement and your questions.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Mr. Chairman, I thank you and I apologize to our witnesses for my tardiness. I would ask unanimous consent that my opening statement be a part of the record and I will use the time for questions.

[The prepared statement of Senator Burr follows:]

PREPARED STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Thank you Mr. Chairman. Welcome to our witnesses this morning.

We are here to look at how VA ensures veterans are receiving quality, cost-effective healthcare services when it purchases those services from the private sector.

I think many would be surprised to learn the extent to which VA relies on outside providers to deliver services to veterans and certain survivors of veterans.

Of course contract care should never be used to supplant the VA health care system. VA provides services that are specialized to the unique needs of veterans and is now known as one of the top providers of medical care in the country. But, in some cases, it does make sense to complement that care with the help of community providers.

I welcome this discussion. I've heard from many North Carolinians who live in rural communities who tell me that while they like the VA health care system, they'd rather avoid the long trip and just see their community doctor in some cases.

For this reason I'm excited about the rural health contract pilot program that was part of Public Law 110–487. VISN 6 will be a part of that pilot, which will give vet-

erans residing long distances from VA medical facilities the option of receiving their care in their community.

Using local community providers can save rural veterans from long, tiresome trips. It can also be a way to deal with veterans' healthcare needs in rural America, especially when there are very few providers to meet the current need, particularly in specialty care. Therefore, establishing relationships with community providers is essential.

Of course when VA uses taxpayer dollars to purchase care for veterans we must ensure that we're getting three key things in return: timely access; quality care; and a fair price for the contracted services.

I look forward to hearing from our witnesses to see if the contracts which are the focus of today's hearing address these three key elements.

A couple of other points I think are worth noting. VA spends more than $3 billion on healthcare provided outside its doors. Obviously some of this care is governed under a contract relationship. But the bulk of it is regular fee-based care.

I'm interested to see what quality and cost mechanisms are in place for fee-based care as well. A comparison between care purchased under contract and regular fee-based care will help determine whether VA should favor one approach over the other.

Finally, I'm interested to see VA's own measures when it comes to performance, quality, and cost. We should hold those VA does business with to the same standard as VA holds itself. To ensure that VA healthcare continues to serve our veterans well, VA must set meaningful measures in place to compare itself with the private sector and vice versa.

Mr. Chairman, I look forward to the testimony and, again, thank you for calling the hearing. I yield back.

Senator BURR. Mr. Baker, I will direct this at you. Well, let me pickup on what Senator Begich was asking. Does the VA track error rates in fee-for-service health care provided? With fee-based health care, do you track the error rates?

Mr. BAKER. We do not have an effective mechanism of identifying the error rate to track at this point, Senator.

Senator BURR. That is in large measure because the patient may only go to the fee-based physician once or the times that are prescribed by the VA and there is no requirement by the provider to supply the medical outcome from a standpoint of what their observation was or their treatment was. Is that correct?

Mr. BAKER. In contracted care and we do——

Senator BURR. I am separating contract care from fee-based. In contracting care, you can stipulate in the contract that they have to report their error experience.

Mr. BAKER. With our past practice, we may or may not have gotten the medical information, which I think is your point. We have modified our directions to the local facilities indicating that they should indicate on the individual authorization forms a requirement that providers provide to VA the medical information generated by the treatment that was authorized.

Senator BURR. Is it not safe to say that if we do not capture the treatment that was provided, then we have an incomplete medical history on that veteran?

Mr. BAKER. That would be correct, sir.

Senator BURR. Within the VA system, if the rest of their care was delivered there, it would be delivered without the knowledge of that one, two, or three times that they went outside the system at the direction of the VA?

Mr. BAKER. If that information is not available nor sent back to us, you are correct, sir.

Senator BURR. I have been contacted by a urologist in North Carolina who is now refusing to see any new VA patients. He indi-

cates that it is due to a history of VA diagnosing patients and then sending them outside with less than complete evaluations required and no additional clinical surveillance.

I do not want to practice medicine in this hearing. But my point would be this: are we asking for the right things when we send people out and do we attempt to do any post-treatment surveillance that is beneficial to the overall health care treatment of the veteran?

Mr. BAKER. My reaction, sir, is that we do try to do that. That the fee-basis and contract care both are considered an integral part of our treatment of veterans and that we do have monitoring systems and quality performance standards in place so that whether the care is outside of VA or inside the VA that we monitor the outcome for the patient.

Senator BURR. But there is no requirement on any fee-based service to provide the medical records to the VA, am I correct?

Mr. BAKER. If we indicated that on the authorization form as I indicated earlier, then we would expect that that is an implied contract and they would provide that information to us, sir.

Senator BURR. What are the three things that trigger within VA the decision to contract outside or to arrange for a fee-based service outside?

Mr. BAKER. Availability within VA and geographic accessibility are the principal issues.

Senator BURR. OK. Any other ones?

Mr. BAKER. I cannot remember off the top, sir.

Senator BURR. Good. According to the National Council for Community Behavioral Health Care, VA is competing for the limited number of mental health providers, a situation that may be, and I quote, ". . . exacerbating an existing mental health workforce shortage, and potentially compromising the long-term treatment and rehabilitation needs of returning veterans."

What has been suggested is a model of collaboration versus a VA attempt to take all of the health care professionals in mental health and bring them under the VA's ownership.

What are your thoughts about the idea of creating these targeted partnerships with existing community providers?

Mr. WILLIAMS. Senator, I would suggest we look for every opportunity to partner within the community to find a way to improve our access for our veterans and to provide the care that they need.

We work very closely with our affiliations in universities and medical schools across the country to meet many other specialty care needs.

With regards to the idea of a model where we can improve our access to care and to be a greater partner in the delivery of that service, I would think that would be a good idea.

But, we continue to be afforded the opportunity to meet or exceed the expectations of the mental health community. We work diligently to try to get those providers, those specialist, that staff on board, and oftentimes as an adjunct to the recruitment and retention that we enjoy, we still have to rely on our universities and our community partners to provide that service.

To answer your question, again I think we look forward to the opportunity to explore partnership opportunities to improve access.

Senator BURR. I appreciate that because I think it is an important component. I hope you understand that we are concerned about what the council raised and that is, if the VA absorbs 99 percent of the mental health providers into the VA system, there is nobody to partner with on the outside.

I think they are raising a red flag very early to say maybe the goal within the Veterans Administration—from the standpoint of having all the mental health providers on the employment of the Veterans Administration—might cause a real problem.

I mean statistically, 25 percent of enrollees in the VA seek all their care within the VA, while 75 percent treat some combination of care with both the VA and outside.

For mental health we are getting to a point with the number of providers available outside of the VA system that vets are going to have to seek 100 percent of their mental health care within the VA because that is going to be where the only providers are.

I understand the unbelievable requirements within the system now to treat mental health. Much of it emanates from this Committee. I would only say it is time to understand why the council is releasing this red flag for us to rethink whether we want a good balance of private providers in mental health matched with employees of the Veterans Administration. If not, we are limited to one path and that path is not necessarily always the most cost-effective or the most effective from the standpoint treatment.

I thank the Chairman for allowing me to go over.

Chairman AKAKA. Thank you very much, Senator Burr.

I would like to call on Senator Burris for his questions.

STATEMENT OF HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Senator BURRIS. Thank you, Mr. Chairman.

Mr. Chairman, I have an opening statement. I would ask for unanimous consent that it also be included in the record.

Chairman AKAKA. It will be included in the record.

[The prepared statement of Senator Burris follows:]

PREPARED STATEMENT FROM HON. ROLAND W. BURRIS, U.S. SENATOR FROM ILLINOIS

Thank you, Mr. Chairman. I am glad that our committee has decided to tackle this important issue today, because I believe that we are not seeing the proper transparency and accountability in the VA's contracting procedures.

I fully appreciate that in some cases the VA must seek services outside of VA facilities. For example, it would not be cost-effective for the VA to staff every potential medical specialist in every geographic area.

It is perfectly reasonable to use outside providers in these cases.

However, I am concerned that VA may be relying on outside entities too heavily, and that some contracts may not provide the best possible service or value to our veterans.

Contracts should be used sparingly, and only in cases where the VA is unable to effectively provide a necessary service.

As I have said many times, our veterans deserve the best possible care, and no entity is in a better position to understand the unique needs of our veterans than VA providers.

Through this hearing, I hope we can clarify the VA's method for determining the costs and benefits of contract services and work toward improvements in that process.

Senator BURRIS. I will go straight to my questions to follow up on what Senator Burr and Senator Begich asked.

I am concerned about—could you give me an accounting of the costs associated with the HERO project when compared to the fee-for-service model. Is there an accounting that you can give for that?

Mr. WILLIAMS. Mr. Baker will take that question, sir.

Mr. BAKER. We have done an analysis of the HERO contract. I think you heard Mr. Williams indicate that at a very high level the Humana contract in general 89–90 percent are at Medicare level or below and that Delta Dental is 80 percent or below of the dental standard.

In terms of actual costs per patient——

Senator BURRIS. Yes.

Mr. BAKER [continuing]. The cost per patient for the HERO patient is something over $1,000 for medical care—outpatient medical care. The gross fee per patient is over $4,200.

I am not sure that the comparison of patient to patient in HERO and all of the fee programs is necessarily a direct comparison but those are how the numbers come out.

In terms of Delta Dental, the fee average cost of $1,600 and the average for HERO was approximately $1,500. So approximately $100 less.

Senator BURRIS. So, that is the side-by-side fee for service.

Mr. BAKER. Comparison of fee versus the HERO costs per patient.

Senator BURRIS. Why is it that the contract services are necessary for 20 percent of compensation and pension medical examinations?

Mr. WILLIAMS. Mr. Mayes.

Senator BURRIS. Mr. Mayes.

Mr. MAYES. Yes, Senator. Essentially, it is the same criteria that Mr. Baker pointed out earlier. It is an access issue. We looked around the country at areas where the VHA was having a challenge in I guess providing the C&P exams in a timely manner. Some of those challenges were related to securing adequate folks to do those exams.

When we analyzed the lay of the land with regard to providing those needs, we collaborated with VHA and we put contracts in place that covered those jurisdictions.

Senator BURRIS. So, why cannot the VA hire those physician directly? You said there is a problem with the VA staffing and recruitment in this regard?

Mr. MAYES. I cannot speak to whether or not VHA can hire the physicians directly. What I can say is that when we were trying to target where it was we were going to utilize the contracted services, we were looking at the performance of the VHA exams at the time. This goes back to, initially, 1998 with the QTC contract.

So, that was the basis for where it was within the country that we were going to target these contracted services. I would defer to my colleagues with respect to the hiring.

Senator BURRIS. What about the QTC contract that is in close proximity to Washington, DC, in Alexandria, VA? Why is the VA unable to directly hire examiners in our Nation's capitol? I mean you are contracting right out here in the vicinity?

Mr. MAYES. We are utilizing, for example, QTC exam providers in support of our BDD program. Two of the regional offices handle

our BDD and quick start claims. So we have an opportunity to have exam providers in close proximity to military installations where we have servicemembers who are separating.

Senator BURRIS. Is there a VA hospital here in the vicinity? VA facilities here?

Mr. MAYES. Yes, Senator, there is.

Senator BURRIS. Is there a staffing problem there?

Mr. MAYES. Again I would have to defer to my colleagues on staffing the C&P exams directly.

Mr. WILLIAMS. Senator, I am not aware of any specific staffing problems, particularly at the DC facility. There are only three facilities in the immediate area: the DC facility which handles the primary catchment area for the District and some of the surrounding counties; Martinsburg VA Medical Center, which is a much smaller facility; and then we have a Baltimore facility, which is an acute care facility.

With regards to, and again I cannot speak to QTC, but with regards to the recruitment piece, typically where we have challenges is in the specialty area where we are trying to find neurologists or where we might be looking at audiology, and some of those specialties.

When we look at this, we look at it from a couple of standpoints. One is, are we able to complete an examination in 35 days. That is one of our marks that we have been looking at. So, it is a rate.

On average on a national basis, we complete these physicals in about 30 days, but we do have outliers. We do have a monitoring system in place where if we see a trend of 2 months where there is an increase in the rate, if it goes beyond the 35 days, then we intervene from a leadership standpoint. Many of our facilities are able to complete those physicals in less than 30 days.

The other piece is a quality measure. I think VBA might be able to speak more definitively to that. But in the quality measure, we look at the number of returned physicals.

If we get a significant number, whatever that threshold may be, then there is an indication there with regard to the amount of staffing, training and education of the staffing, and possibly of the availability of specialists that can address these issues.

The third component is the satisfaction piece, what feedback we get from the veterans that are receiving these types of services and benefits.

But with regard specifically to the Washington area, I am not personally aware of any hiring challenges. From time to time, depending on the rate and volume of physicals that we get at any one time, we do have some challenges with getting those out in a timely manner. Then we rely on QTC and other means to address those physical exam needs.

Senator BURRIS. Thank you, Mr. Chairman. I am sorry my time did go over. Thank you very much.

Chairman AKAKA. Thank you, Senator Burris.

Mr. Williams, I understand VA is creating four new regional offices to oversee local contracts. My question is: what are the advantages of this new structure and how will it fix some of the issues that are being discussed at this time: over billing; quality-control; and access to care?

Mr. WILLIAMS. Thank you, Mr. Chairman. I will defer to Mr. Downs.

Chairman AKAKA. Mr. Downs.

Mr. DOWNS. Mr. Chairman, this is a whole movement toward professionalism of acquisition in the Veterans Health Administration and throughout VA.

We have implemented a number of initiatives. Mr. Frye, when he came on board in his position, he had PriceWaterhouseCooper do a review of all VA acquisition. They came forth with a number of recommendations that would improve the efficiency of our operation and improve acquisition in the areas of quality, oversight, monitoring, policy, procedures, standardization, and business practices, and put all of the acquisition people into one chain of command from the facility level all the way up to Washington and remove the influence of the local directors, the network directors, and others so that the acquisition officer, the contracting officer, could concentrate on his job—fulfilling the requirements of the program managers in developing the requirements, getting the contracts out, and making sure that they are properly monitored and that oversight was conducted.

This whole process is going to make us much more efficient. We are dealing with nearly 22,700 active contracts this year. These individuals who do these contracts with this new organization—we will be able to make sure that they receive all the training that is required; that they will be properly certified. In fact, that is a requirement. They cannot perform their jobs unless they are certified. They will have continuing education.

The four regional offices. Their job is to: monitor the quality of the contracts; do the audits; make sure that they are compliant with all the regulations; and make sure they follow up on the COTRs, which the contracting technical representatives who are the program folks responsible for monitoring the contract to make sure it is being met, which relates to some of the earlier questions.

So, this is a whole movement toward professionalizing and moving our acquisition organization up in line, not only with the other agencies in the government, but to move us forward into the 21st century.

Chairman AKAKA. Thank you.

Mr. Williams, the Office of Management and Budget directed Federal agencies to end their overreliance on contractors. What has VA done to comply with this direction?

Mr. WILLIAMS. Mr. Chairman, I defer to Mr. Jan Frye.

Mr. FRYE. Thank you, Mr. Chairman. In accordance with the Office of Management and Budget's direction of July 29, 2009, each agency subject to the CFO Act—the Chief Financial Officer Act—must conduct a pilot under which they perform a multi-sector, human capital analysis of at least one organization, program, project, or activity where there are concerns about the extent of reliance on contractors and take appropriate steps to address any identified weaknesses.

The VA is in the process of identifying a program or activity that will serve as VA's pilot program. The VA is due to notify OMB of its candidate organization for the pilot employee program tomorrow, October 1.

Chairman AKAKA. I am glad to hear this. It was mentioned during the testimony that there is, as you said, a policy not to rely entirely on contractors.

Mr. Williams, QTC was awarded additional years on its contract for good performance. Yet a report by the Inspector General on payment issues under the contract resulted in QTC paying VA millions of dollars because of overbilling. Can you explain this apparent inconsistency?

Mr. WILLIAMS. Sir, I will defer to Mr. Mayes.

Chairman AKAKA. Mr. Mayes.

Mr. MAYES. Mr. Chairman, I will take that question. First of all, I would like to point out that the VA had brought in an auditor and had discovered the overbilling in the first place. The OIG then came in following the audit that we had implemented and identified or confirmed some of that overbilling.

Following that, we sent a bill of collection to QTC and they did repay the government for the overbilling. They not only repaid the overbilling for the term of the initial audit that we had initiated, but also going back to the beginning of the contract. So, QTC was very forthcoming and repaid the government.

Regarding the award terms, the way the contract was structured was based on performance from the veteran's perspective: the timeliness of the exam; the quality of the exam report, as we talked about; and then customer satisfaction.

So, the award terms based on that contract were not linked to billing. QTC has met the performance targets that were established in the contract. I would mention that they did not receive award terms for all of the years of the contract, which were one base year and four option years. They only received award terms for 3 out of those 5 years.

I hope that answers your question, Mr. Chairman.

Chairman AKAKA. Thank you.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

I wanted to go back to my previous round of questions and get clarification. I assume we go through Mr. Williams, though I think you are probably going to refer it to Mr. Mayes because it was a question he answered.

The VA does track the outcomes of disability ratings by the contract and by the VA. I believe that is what I heard you say and I just want to make sure that that is correct.

Mr. MAYES. We track the exam quality, not the rating outcome. The quality of the exam in many cases forms the basis for the rating decision.

Senator TESTER. OK. But ultimately in the end you track the outcomes of those exams that are done as far as potential problems that the vet would have. Do you track those kind of things, if they are appealed, all that stuff?

Mr. MAYES. No, sir, we do not track whether they are appealed.

Senator TESTER. So, not to put words in your mouth, but what you are tracking is performance and timeliness of the exams, to refer to the Chairman's question?

Mr. MAYES. Performance in terms of timeliness, performance in terms of quality as measured with compliance to the exam template, and then performance with respect to customer satisfaction.

Senator TESTER. How do you determine the customer satisfaction? That is what I am getting at.

Mr. MAYES. Understood, Senator. I am sorry if I created——

Senator TESTER. No, you have not.

Mr. MAYES. The customer satisfaction—we have a separate contract with another vendor. They administer customer satisfaction questionnaires. Those questionnaires are provided to the veteran prior to——

Senator TESTER. Can you tell me what the results of those questionnaires are as far as the contractor versus the VA exams?

Mr. MAYES. I can only speak to the contractors. C&P Service administers the contracts for QTC and for MES, the two providers. Veterans say they are consistently highly satisfied.

Senator TESTER. They are consistently highly satisfied with the work that the contractors are doing. How about the VA? Are they consistently highly satisfied with the work the VA is doing?

Mr. MAYES. I cannot speak to that, Senator. I will have to defer to my colleagues.

Mr. BAKER. We do not have a systemwide customer satisfaction specifically for C&P exams. We do have individual medical centers and some networks that have established focus groups, interviews, and some customer satisfaction.

We do have an initiative to initiate such a customer satisfaction program in 2010.

Senator TESTER. All right. I want to go back to the previous round of questions. I just want to make sure my understanding is correct; and this is probably for Mr. Mayes again.

You give the contractors a VA template or form but you do not train them, and I assume you do not train them how to use that form either; or if I am wrong on that, clarify in any way.

Mr. MAYES. I will take this for the record and provide a fully developed response, Senator. We are interacting with the contractors on a regular basis and we have a staff within C&P Service that is monitoring the exam requests because those requests come from VBA regional office personnel. Then we have a statistical quality control mechanism on the reports that come back.

So, we are looking at if there are problems meeting the quality indicators as the exams come back. We then, are constantly in communication with vendors with respect to any findings that we discover on the reports that are coming back—really with our people too—because we have got to make sure that it is an adequate request. We have to ask for the right exam.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO BRADLEY MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. How do the medical disability examination contractors (QTC and MES) train their medical examiners?

Response. Both Medical Disability Examination contracts require the contractors do the following in consultation with VA:

- Prepare and implement a training program for all examiners;
- Provide orientation and instructions for conducting examinations based on VA worksheets;

• Provide training to ensure that examiners have an appropriate attitude toward veterans and their unique circumstances;
• Explain the concept of presumptive diagnoses in view of the unique circumstances of military service;
• Ensure that examiners understand how to assess and document pain in accordance with VA regulations;
• Provide training to explain the differences between VA disability examination protocols versus examination protocols for treatment purposes;
• Demonstrate a quality assurance program;
• Monitor physicians' offices to ensure veterans are seen within 30 minutes of the appointment time; and
• Make any corrections and return them to VA within 14 business days.

Senator TESTER. It would seem to me that the appeals rate would be something that you would use as a method by which to determine adequacy.

Do you use appeals rates? I am talking about VA versus contractor.

Mr. MAYES. Appeal with the decision?

Senator TESTER. Appeal with the examination. That is correct, when they come back.

Mr. MAYES. The exam is used to form the basis for our entitlement determination.

Senator TESTER. That is correct.

Mr. MAYES. We are not measuring a notice of disagreement with the entitlement determination. We are not looking at that in those cases where that entitlement determination is based on a contract exam as opposed to a VHA-provided exam.

Senator TESTER. Why not? It just seems to me—and just tell me Mr. Williams or Mr. Mayes, if you can tell me what you do now. There is probably a good reason for it.

Mr. MAYES. Senator, I am back to—it is a legal decision. The entitlement determination is a legal decision that is made by our raters in VA regional offices.

Senator TESTER. Based on that exam.

Mr. MAYES. Based on that exam, yes, sir.

If the exam is returned as adequate, whether it comes from VHA or it comes to the contract exam provider, then we have received the information—the medical information, limitation of motion, or the impairment of functioning or medical impairment—we have received what information we need for us then to make the legal determination.

So, we are looking at the quality of the exam to see if it meets our needs, but we are not then going beyond that to look at appeal rates. That is something I can take back.

Senator TESTER. I just want to make sure the vet is treated fairly. Appealing stuff is not fun. And if the appeal rate—and I do not know that it is or is not—if the appeal rate is higher with the contracted versus the in-house examiners, then maybe we need to take a look—or if it is the other way around—take a look at what is going on because that is a big thing.

One last question. The VA budget, does it differentiate—and this probably is not a question for you, Mr. Mayes, so you can take a break.

Mr. MAYES. I appreciate that.

Senator TESTER. Does it differentiate the submission between the costs of providing CBOC contract care and CBOC care provided by

the VA? Can you tell me why there is not a differentiation between those costs provided in the budget?

Mr. WILLIAMS. No, sir, I am not able to answer that specifically. I will take that for the record.

Senator TESTER. If somebody can get back to me on that I would be very appreciative. I appreciate you folks being here today. I appreciate the work you do. I am sorry I cannot be here for the second panel because we could further clarify some of these questions.

Thank you very much.

[The requested information follows:]

Operational CBOCs in FY Annual Costs

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1	402GA	Aroostook County (Caribou)	1	Caribou	ME	L	$ 2,269,381.43	$ 2,045,684.74
1	402GB	Calais	1	Calais	ME	L	$ 1,176,803.07	$ 1,028,245.16
1	402GC	Rumford	1	Rumford	ME	L	$ 1,633,537.12	$ 1,525,101.59
1	402GD	Saco	1	Saco	ME	L	$ 4,279,744.84	$ 4,428,643.37
1	402HB	Bangor	2	Bangor	ME	L	$ 5,763,069.70	$ 5,628,877.37
1	402HC	Portland	1	Portland	ME	L	$ 1,383,924.32	$ 1,337,519.73
1	405GA	Bennington	1	Bennington	VT	L	$ 2,082,616.37	$ 1,773,585.25
1	405HA	Colchester	1	Colchester	VT	L	$ 4,087,564.01	$ 3,084,976.40
1	405HC	VICC - St. Johnsbury - Littleton	2	Littleton	NH	C	$ 1,777,971.58	$ 1,193,137.27
1	405HD	VICC - Newport	1	Newport	VT	L		
1	405HF	Rutland	1	Rutland	VT	C	$ 1,205,653.13	$ 1,206,004.62
1	518GA	Lynn/North Shore	1		MA	L	$ 1,731,995.36	$ 1,103,727.94
1	518GB	Haverhill	1	Haverhill	MA	L	$ 2,155,472.34	$ 1,494,566.36
1	518GC	Winchendon	1	Winchendon	MA	L	$ 264,500.17	$ 273,655.90
1	518GE	Gloucester	1	Gloucester	MA	L	$ 1,302,847.98	$ 808,996.09
1	518GG	Fitchburg	1	Fitchburg	MA	L	$ 1,957,689.38	$ 1,123,392.45
1	523	VA Boston HCS- Boston Div.	1	Boston	MA	V	$ 131,777,507.07	$ 116,563,068.94
1	523BY	Lowell	1	Lowell	MA	L	$ 8,849,456.43	$ 6,223,734.78
1	523BZ	Causeway Clinic (Boston)	1	Boston	MA	L	$ 15,568,776.94	$ 12,810,730.68
1	523GA	Framingham VA Primary Care Unit	1	Framingham	MA	L	$ 1,572,242.42	$ 1,340,831.40
1	523GB	Worcester	1	Worcester	MA	L	$ 13,421,723.43	$ 10,144,318.19
1	523GC	Quincy	1	Quincy	MA	L	$ 839,857.50	$ 874,074.57
1	523GE	Dorchester	1	Dorchester	MA	L	$ 221,613.14	$ 138,468.12
1	608	Manchester	1	Manchester	NH	V	$ 78,205,334.29	$ 77,174,895.67
1	608GA	Portsmouth	1	Portsmouth	NH	L	$ 766,211.95	$ 869,410.00
1	608GC	Somersworth	1	Somersworth	NH	L	$ 1,387,544.22	$ 1,226,603.31
1	608GD	Conway	1	Conway	NH	C	$ 560,625.15	$ 347,918.87
1	608HA	Tilton	1	Tilton	NH	L	$ 939,382.86	$ 827,304.40
1	631BY	Springfield	1	Springfield	MA	L	$ 7,789,067.09	$ 9,002,223.59
1	631GC	Pittsfield	1	Pittsfield	MA	L	$ 1,710,507.40	$ 1,321,117.19
1	631GD	Greenfield (Franklin County)	1	Greenfield	MA	L	$ 1,016,126.12	$ 1,029,764.80
1	650GA	New Bedford Primary Care Ctr.	1	New Bedford	MA	V	$ 2,418,176.07	$ 2,143,692.50
1	650GB	Hyannis Primary Care Center	1	Hyannis	MA	L	$ 2,036,176.50	$ 2,277,065.45
1	650GC	Oaks Bluffs (Martha's Vineyard)	1	Edgartown	MA	C	$ 5,276.95	
1	650GD	Middletown	1	Middletown	RI	L	$ 2,347,412.73	$ 1,732,571.57
1	650GE	Nantucket	1	Nantucket	MA	C	$ 6,126.52	

Prepared by VSSCjp1
Data Source: VAST DSS

Operational CBOCs in FY Annual Costs

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1	689A4	Newington Campus	1	Newington	CT	V	$ 68,331,507.61	$ 58,518,339.65
1	689GA	Waterbury VA Primary Care Center	1	Waterbury	CT	L	$ 1,795,095.15	$ 2,199,281.70
1	689GB	Stamford VA Primary Care Center	1	Stamford	CT	L	$ 1,630,138.02	$ 1,462,891.87
1	689GC	Windham VA Primary Care	1	Willimantic	CT	L	$ 1,025,173.44	$ 1,006,224.24
1	689GD	Winsted VA Primary Care	1	Winsted	CT	L	$ 1,427,508.89	$ 1,460,976.49
1	689GE	Danbury	1	Danbury	CT	L	$ 1,197,949.58	$ 1,118,782.51
1	689HC	New London VA Primary Care Center	1	New London	CT	L	$ 2,697,633.58	$ 2,611,233.81
2	528A4	Upstate New York HCS-Batavia	1	Batavia	NY	V	$ 10,698,734.08	$ 10,190,386.12
2	528G1	Malone	1	Malone	NY	C	$ 1,337,004.14	$ 1,354,514.37
2	528G2	Elizabethtown	1	ELIZABETHTOWN	NY	C	$ 1,101,236.80	$ 787,633.29
2	528G3	Bainbridge	1	Bainbridge	NY	L	$ 1,554,199.84	$ 1,377,921.11
2	528G4	Elmira	1	Elmira	NY	L	$ 2,204,109.18	$ 2,317,936.10
2	528G5	Auburn	1	Auburn	NY	C	$ 1,809,902.71	$ 1,538,490.72
2	528G6	Fonda	1	Fonda	NY	L	$ 1,533,392.68	$ 1,064,048.07
2	528G7	Catskill	1	Catskill	NY	L	$ 1,495,805.85	$ 1,268,938.61
2	528G8	Wellsville	1	Wellsville	NY	L	$ 1,914,338.69	$ 1,880,864.19
2	528G9	Cortland	2	Cortland	NY	C	$ 2,549,551.00	$ 2,085,405.37
2	528GB	Jamestown	1	JAMESTOWN	NY	C	$ 2,215,634.54	$ 1,624,841.21
2	528GC	Dunkirk	1	DUNKIRK	NY	C	$ 1,776,817.03	$ 1,849,932.62
2	528GD	Niagara Falls	1	NIAGARA FALLS	NY	L	$ 2,445,983.97	$ 2,333,912.00
2	528GE	Rochester	1	ROCHESTER	NY	L	$ 26,981,600.75	$ 26,884,737.02
2	528GK	Lockport	1	Lockport	NY	C	$ 1,161,564.76	$ 1,370,187.00
2	528GL	Massena	1	Massena	NY	C	$ 3,254,940.08	$ 2,538,796.85
2	528GM	Rome	1	ROME	NY	V	$ 11,406,225.43	$ 9,226,142.70
2	528GN	Binghamton	1	Binghamton	NY	L	$ 6,227,198.93	$ 6,397,774.39
2	528GO	Carthage	1	Carthage	NY	C	$ 4,366,931.88	$ 3,760,983.57
2	528GP	Oswego	1	Oswego	NY	C	$ 2,577,673.62	$ 1,609,820.66
2	528GQ	Lackawanna	2	Lackawanna	NY	C	$ 2,164,534.00	$ 2,091,296.05
2	528GR	Olean	1	Olean	NY	L	$ 2,309,926.38	$ 2,318,296.46
2	528GT	Glens Falls	1	Glens Falls	NY	C	$ 3,529,767.57	$ 2,459,456.31
2	528GV	Plattsburgh	1	PLATTSBURGH	NY	C	$ 2,485,274.24	$ 2,314,521.54
2	528GW	Schenectady	1	Schenectady	NY	C	$ 1,762,562.57	$ 1,703,175.11
2	528GX	Troy	1	Troy	NY	C	$ 1,211,071.78	$ 970,050.46
2	528GY	Clifton Park	1	Clifton Park	NY	L	$ 1,972,687.95	$ 1,516,143.02
2	528GZ	Kingston	1	Kingston	NY	C	$ 2,249,043.61	$ 1,845,323.91
2	528J1	Warsaw	1	Warsaw	NY	L	$ 282,834.10	$ 211,918.51
3	526GA	White Plains	1	White Plains	NY	L	$ 1,416,032.76	$ 1,370,463.19
3	526GB	Yonkers	1	Yonkers	NY	L	$ 1,008,915.59	$ 904,974.11
3	526GC	South Bronx	1	Bronx	NY	L	$ 246,983.93	$ 221,538.56

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3	526GD	Queens	1	Sunnyside	NY	L	$ 594,448.91	$ 406,101.32
3	561BY	Newark	1	NEWARK	NJ	L	$ 2,864,071.58	$ 2,605,043.97
3	561BZ	Brick	1	Brick	NJ	L	$ 18,640,039.13	$ 13,344,515.01
3	561GA	Trenton	1	Trenton	NJ	L	$ 3,214,610.01	$ 2,421,958.31
3	561GB	Elizabeth	1	Elizabeth	NJ	L	$ 1,647,850.43	$ 1,509,574.22
3	561GD	Hackensack/Bergen County	1	Hackensack	NJ	L	$ 7,896,137.08	$ 6,616,042.94
3	561GE	Jersey City	1	Jersey City	NJ	L	$ 1,408,609.71	$ 1,039,364.74
3	561GF	New Brunswick	1	New Brunswick	NJ	L	$ 1,366,407.78	$ 1,386,308.72
3	561GG	Newark	1	Newark	NJ	L	$ 214,844.53	$ 93,754.58
3	561GH	Morristown	1	Morris Plains	NJ	L	$ 1,482,040.31	$ 1,329,854.53
3	561GI	Monmouth County, NJ	1	Fort Monmouth	NJ	L	$ 2,141,591.66	$ 2,277,000.43
3	561GJ	Paterson	1	Paterson	NJ	V	$ 1,096,000.05	$ 1,155,383.70
3	620GA	New City (Rockland County)	1	New City	NY	L	$ 3,845,052.86	$ 3,394,748.76
3	620GB	Carmel (Putnam County)	1	Carmel	NY	L	$ 2,014,481.41	$ 1,694,268.40
3	620GD	Middletown	1	Middletown	NY	L	$ 2,137,062.04	$ 2,088,003.34
3	620GE	Port Jervis	1	Port Jervis	NY	L	$ 1,653,076.01	$ 1,553,905.90
3	620GF	Harris (Monticello)	1	Monticello	NY	L	$ 1,145,960.17	$ 923,349.48
3	620GG	Poughkeepsie	1	Poughkeepsie	NY	L	$ 1,478,200.20	$ 1,180,391.55
3	620GH	Eastern Dutchess	1	Pine Plains	NY	L	$ 369,216.86	$ 281,205.35
3	630A5	New York Harbor HCS-St. Albans Campus	1	Jamaica	NY	V	$ 15,427,177.63	$ 13,190,123.14
3	630BZ	New York SOC	1	New York	NY	L	$ 1,703,096.39	$ 1,450,437.75
3	630GA	Harlem	1	New York	NY	L	$ 740,745.45	$ 663,860.68
3	630GB	Staten Island	1	Staten Island	NY	V	$ 2,232,304.84	$ 1,767,910.00
3	630GC	Chapel St	1	Brooklyn	NY	L	$ 3,325,268.81	$ 3,019,582.19
3	632GA	Plainview	1	Plainview	NY	L	$ 2,520,840.25	$ 2,356,175.58
3	632HA	Lynbrook	1	Lynbrook	NY	L	$ 304,239.61	$ 233,908.28
3	632HB	Riverhead	1	Riverhead	NY	L	$ 533,991.52	$ 302,284.12
3	632HC	Islip	1	Islip	NY	L	$ 150,864.58	$ 132,829.54
3	632HD	Patchoque	1	Patchogue	NY	L	$ 1,538,559.04	$ 1,288,733.12
3	632HE	Mt. Sinai	1	Mt Sinai	NY	L	$ 1,618.12	
3	632HF	Lindenhurst	1	Lindenhurst	NY	L	$ 282,843.04	$ 237,571.95
4	460GA	Millsboro VA Primary Care Clinic	1	Millsboro	DE	L	$ 1,143,252.01	$ 608,662.93
4	460GC	Dover	1	Dover	DE	L	$ 112,841.64	$ 388,472.81
4	460GD	Cape May County	1	Cape May	NJ	V	$ 1,375,577.35	$ 955,682.98
4	460HE	Ventnor	1	Ventnor	NJ	L	$ 1,077,329.54	$ 460,524.32
4	460HG	Vineland	1	Vineland	NJ	L	$ 1,018,737.47	$ 541,846.11
4	503GA	Johnstown	1	Johnstown	PA	L	$ 4,325,120.07	$ 3,613,908.42
4	503GB	DuBois (Clearfield)	1	DuBois	PA	L	$ 2,787,875.70	$ 2,634,895.66

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4	503GC	State College (Centre County)	1	State College	PA	L	$ 2,392,083.23	$ 2,325,570.02
4	529GA	Mercer County	1	Hermitage	PA	L	$ 1,707,584.79	$ 2,041,844.80
4	529GB	Lawrence County	1	New Castle	PA	L	$ 957,024.52	$ 1,223,266.89
4	529GC	Armstrong County (Kittanning)	1	Kittanning	PA	C	$ (45,394.43)	$ 833,895.45
4	529GD	Clarion County	1	Parker	PA	C	$ (28,097.67)	$ 845,848.04
4	540GA	Tucker County Veterans Center	1	Parsons	WV	L	$ 620,636.41	$ 473,939.57
4	540GB	Wood County Veterans Center	1	Parkersburg	WV	L	$ 2,241,798.40	$ 3,297,069.66
4	540GC	Gassaway-Braxton County	1	Sutton	WV	L	$ 944,780.23	$ 695,625.92
4	540GD	Monongalia	1	Westover	WV	L	$ 9,537.58	$ 989,455.53
4	542GA	Springfield	1	Springfield	PA	L	$ 2,401,649.91	$ 2,026,244.05
4	542GE	Spring City	1	Spring City	PA	V	$ 1,756,040.20	$ 1,487,185.22
4	562GA	Crawford County Primary Care Clinic	1	Meadville	PA	L	$ 1,704,834.15	$ 1,457,077.91
4	562GB	Ashtabula County Primary Care Clinic	1	Ashtabula	OH	L	$ 1,323,545.36	$ 1,156,899.28
4	562GC	McKean County Primary Care Clinic	1	Bradford	PA	C	$ 384,988.31	$ 617,401.45
4	562GD	Venango	1	Franklin	PA	L	$ 1,001,659.05	$ 1,189,059.43
4	562GE	Warren	1	Warren	PA	L	$ 1,191,361.67	$ 1,037,690.98
4	595GA	Camp Hill Outpatient Clinic	1	Camp Hill	PA	L	$ 7,196,007.28	$ 5,770,695.11
4	595GC	Lancaster	1	Lancaster	PA	L	$ 1,714,161.68	$ 1,348,940.25
4	595GD	Reading	1	Reading	PA	L	$ 2,264,275.32	$ 1,613,280.67
4	595GE	York County	1	York	PA	L	$ 3,379,764.74	$ 3,434,775.56
4	595GF	Pottsville/Fracksville	2	Pottsville	PA	C	N/A	$ 798,812.99
4	642GA	Outpatient Clinic at Marshall Hall	1	Ft. Dix	NJ	V	$ 6,202,683.53	$ 6,717,102.09
4	642GC	Victor J. Saracini VA Outpatient Clinic	1	Horsham	PA	L	$ 3,200,047.63	$ 4,662,791.59
4	642GD	Gloucester County	1	Sewell	NJ	L	$ 2,147,823.54	$ 2,118,575.47
4	642GE	Philadelphia	1	Philadelphia	PA	L	$ 433,435.07	$ 912,533.14
4	646A4	Heinz Division HCS	1	Pittsburgh	PA	V	$ 15,715,585.00	$ 15,251,992.18
4	646GA	Belmont	1	St. Clairsville	OH	C	$ 2,082,702.78	$ 1,735,065.63
4	646GB	Westmoreland	1	Greensburg	PA	C	$ 1,991,457.30	$ 1,978,765.77
4	646GC	Beaver	1	Monaca	PA	C	$ 1,264,361.14	$ 1,252,125.82
4	646GD	Washington County	1	Washington	PA	C	$ 2,201,785.26	$ 2,035,469.46
4	646GE	Uniontown	1	Uniontown	PA	C	$ 1,107,196.47	$ 1,150,328.23
4	693B4	Allentown	1	Allentown	PA	L	$ 11,726,211.06	$ 9,362,649.44
4	693GA	Sayre	1	Sayre	PA	L	$ 3,447,791.80	$ 3,428,743.73
4	693GB	Williamsport	1	Williamsport	PA	L	$ 1,414,236.75	$ 1,925,218.54

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Operational CBOCs in FY Annual Costs

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4	693GC	Tobyhanna	1	Tobyhanna	PA	L	$ 2,365,804.96	$ 2,594,420.77
4	693GF	Berwick (Columbia Co.)	1	Berwick	PA	C	$ 513,309.97	$ 474,707.78
4	693GG	Northampton County	1	Bangor	PA	L	$ 459,191.30	$ 633,545.21
5	512GA	Cambridge	1	Cambridge	MD	L	$ 6,204,284.94	$ 4,496,003.65
5	512GC	Glen Burnie	1	Glen Burnie	MD	L	$ 4,271,859.15	$ 3,688,018.87
5	512GD	Loch Raven	1	Baltimore	MD	V	$ 7,265,698.75	$ 9,504,126.91
5	512GE	Pocomoke City	1	Pocomoke City	MD	L	$ 1,006,922.37	$ 891,428.12
5	512GF	Fort Howard	1	Fort Howard	MD	V	$ 5,178,888.49	$ 5,122,696.64
5	613GA	Cumberland	1	Cumberland	MD	L	$ 3,185,810.86	$ 2,757,613.97
5	613GB	Hagerstown	1	Hagerstown	MD	L	$ 3,138,888.73	$ 2,803,653.10
5	613GC	Stephens City	1	Kernstown	VA	L	$ 2,606,767.12	$ 2,221,319.54
5	613GD	Franklin	1	Franklin	WV	C	$ 236,645.18	$ 197,406.78
5	613GE	Petersburg	1	Petersburg	WV	C	$ 788,856.88	$ 623,226.43
5	613GF	Harrisonburg	1	Harrisonburg	VA	C	$ 2,567,439.90	$ 1,616,821.91
5	688GA	Alexandria	1	Alexandria	VA	L	$ 741,944.96	$ 1,154,812.92
5	688GB	Southeast Washington	1	Washington	DC	L	$ 902,760.95	$ 663,954.26
5	688GC	Landover/Greenbelt (Prince Georges County)	1	Greenbelt	MD	L	$ 1,078,286.21	$ 954,705.08
5	688GD	Charlotte Hall	1	Charlotte Hall	MD	L	$ 941,640.72	$ 1,363,086.64
6	558GA	Greenville	1	Greenville	NC	L	$ 5,454,319.05	$ 6,182,810.81
6	558GB	Raleigh	1	Raleigh	NC	L	$ 6,140,844.73	$ 6,439,542.36
6	558GC	Morehead City	1	Morehead City	NC	L	$ 3,010,679.68	$ 3,819,172.17
6	565GA	Jacksonville	1	Midway Park	NC	L	$ 1,920,598.25	$ 2,240,273.74
6	565GC	New Hanover County (Wilmington)	1	Wilmington	NC	C	$ 3,587,190.45	$ 2,529,053.10
6	565GD	Hamlet	1	Hamlet	NC	L	$ 711,923.24	$ 818,902.11
6	590GB	NORFOLK-VIRGINIA BEACH	1	Virginia Beach	VA	L	$ 6,270,991.20	$ 5,095,721.16
6	637GA	Franklin	1	Franklin	NC	L	$ 186,874.45	$ 1,844,674.12
6	652GA	Stafford/Fredericksburg	1	Fredericksburg	VA	L	$ 1,815,788.17	$ 1,575,515.68
6	652GE	Charlottesville	1	Charlottesville	VA	L	$ 530,541.26	$ 1,014,055.59
6	658GA	Tazewell	1	Tazewell	VA	C	$ 1,583,886.98	$ 1,275,217.42
6	658GB	Danville	9	Danville	VA	C	$ 4,599,083.13	$ 5,503,158.13
6	658GC	Lynchburg	1	Lynchburg	VA	L	$ 260,933.77	$ 2,973,455.98
6	658HA	Stuarts Draft	1	Stuarts Draft	VA	L	$ 20,228.80	$ 33,351.08
6	658HC	Lynchburg	1	Lynchburg	VA	L	$ 50,821.17	$ 3,952.37
6	658HG	Covington	1	Covington	VA	L	$ 13,209.36	$ 25,233.22
6	659BY	Winston-Salem	1	Winston-Salem	NC	L	$ 40,128,667.61	$ 32,013,615.37
6	659GA	Charlotte	1	Charlotte	NC	L	$ 10,511,726.52	$ 27,679,187.29
6	659GB	Hickory	1	Hickory	NC	L	$ 1,725,679.60	$ 5,015,354.02
7	508GA	East Point	1	East Point	GA	L	$ 4,980,238.93	$ 5,520,371.91

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7	508GE	NE Georgia/Oakwood	1	Oakwood	GA	L	$ 2,909,500.44	$ 3,105,372.06
7	508GF	Smyrna	1	Smyrna	GA	L	$ 3,399,805.02	$ 3,614,268.40
7	508GG	Stockbridge	1	Stockbridge	GA	V	$ 233.77	$ 1,866,110.32
7	508GH	Lawrenceville (Gwinnett County)	1	Lawrenceville	GA	L	$ 4,002,171.50	$ 4,623,935.27
7	508GI	Newnan	1	Newnan	GA	L	N/A	N/A
7	509GA	Athens	1	Athens	GA	L	$ 3,987,843.74	$ 3,080,090.09
7	509GB	Aiken	1	Aiken	SC	L	$ 1,460,484.76	$ 1,822,325.90
7	521GA	Huntsville AL	1	Huntsville	AL	L	$ 3,932,518.55	$ 3,802,102.53
7	521GB	Decatur AL/Madison	1	Madison	AL	L	$ 2,143,381.27	$ 2,339,515.44
7	521GC	Florence AL (Shoals Area)	1	Sheffield	AL	L	$ 2,293,807.81	$ 2,095,164.01
7	521GD	Rainbow City	1	Gadsden	AL	L	$ 2,721,247.28	$ 2,168,319.58
7	521GE	Anniston/Oxford AL	1	Oxford	AL	L	$ 2,556,793.87	$ 2,861,910.28
7	521GF	Jasper AL	1	Jasper	AL	L	$ 707,522.69	$ 861,754.17
7	521GG	Bessemer	1	Bessemer	AL	L	$ 2,749,076.71	$ 2,290,067.69
7	521GH	Childersburg	1	Childersburg	AL	L	N/A	$ 706,835.91
7	534BY	Savannah	1	Savannah	GA	L	$ 12,191,514.46	$ 12,355,098.72
7	534GB	Myrtle Beach	1	Myrtle Beach	SC	V	$ 10,858,605.37	$ 11,109,154.01
7	534GC	Beaufort	1	Beaufort	SC	L	$ 3,299,683.31	$ 3,301,421.53
7	534GD	Goose Creek, SC	1	North Charleston	SC	L	$ 7,887,898.17	$ 7,802,091.38
7	544BZ	Greenville SC	1	Greenville	SC	L	$ 23,009,645.52	$ 19,641,414.60
7	544GB	Florence SC	1	Florence	SC	L	$ 6,026,010.37	$ 4,583,297.40
7	544GC	Rock Hill	1	Rock Hill	SC	C	$ 11,414,514.02	$ 4,899,432.97
7	544GD	Anderson County	1	Anderson	SC	L	$ 4,691,857.68	$ 4,398,572.57
7	544GE	Orangeburg County	1	Orangeburg	SC	L	$ 2,477,950.81	$ 2,446,615.78
7	544GF	Sumter County	1	Sumter	SC	L	$ 3,208,290.05	$ 3,055,124.76
7	544GG	Spartanburg	1	Spartanburg	SC	L	N/A	$ 2,553,382.87
7	557GA	Macon GA	1	Macon	GA	C	$ 5,277,904.53	$ 4,520,901.77
7	557GB	Albany GA	1	Albany	GA	C	$ 6,994,777.08	$ 3,743,704.54
7	619GA	Columbus	1	Columbus	GA	L	$ 7,959,355.32	$ 7,718,790.32
7	619GB	Dothan	1	Dothan	AL	C	$ 5,875,571.93	$ 5,894,523.36
8	516BZ	Ft. Myers	1	FT MYERS	FL	L	$ 49,474,168.71	$ 43,514,457.59
8	516GA	Sarasota	1	Sarasota	FL	L	$ 12,221,234.89	$ 10,857,415.35
8	516GB	S St Petersburg	1	St. Petersburg	FL	L	$ 1,349,164.31	$ 1,139,275.52
8	516GC	Clearwater	1	Dunedin	FL	L	$ 5,438,569.80	$ 5,232,706.28
8	516GD	Manatee	1	Ellenton	FL	L	$ 3,853,043.90	$ 3,655,139.34
8	516GE	Port Charlotte/Charlotte County	1	Port Charlotte	FL	L	$ 8,061,712.81	$ 7,567,059.08
8	516GF	Naples/Collier County	1	Naples	FL	L	$ 4,863,217.14	$ 4,193,263.09
8	516GH	Avon Park - Highlands County	1	Sebring	FL	L	$ 2,717,254.30	$ 2,344,242.59
8	546BZ	Broward County	1	OAKLAND PARK	FL	L	$ 29,279,738.81	$ 26,663,386.05

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8	546GA	Miami	1	Miami	FL	L	$ 5,377,834.41	$ 5,392,726.66
8	546GB	Key West	1	KEY WEST	FL	V	$ 3,064,790.71	$ 2,057,197.82
8	546GC	Homestead	1	HOMESTEAD	FL	C	$ 889,415.12	$ 760,554.06
8	546GD	Pembroke Pines	1	Hollywood	FL	L	$ 3,283,230.21	$ 2,908,513.63
8	546GE	Key Largo	1	KEY LARGO	FL	L	$ 2,157,286.06	$ 1,995,567.68
8	546GF	Hollywood (Southeast Broward Co.)	1	Hollywood	FL	L	$ 2,766,542.97	$ 2,349,720.19
8	546GG	Coral Springs	1	Coral Springs	FL	C	$ 1,492,158.19	$ 704,395.89
8	546GH	Deerfield Beach	1	Deerfield	FL	C	$ 1,129,089.11	$ 586,187.95
8	548GA	Ft Pierce	1	FT PIERCE	FL	C	$ 5,850,489.99	$ 5,499,901.21
8	548GB	Delray Beach	1	Delray Beach	FL	C	$ 9,261,262.85	$ 7,853,895.09
8	548GC	Stuart	1	Stuart	FL	C	$ 5,437,769.15	$ 5,087,014.47
8	548GD	Boca Raton	1	Boca Raton	FL	C	$ 3,790,485.22	$ 4,038,342.53
8	548GE	Vero Beach	1	Vero Beach	FL	C	$ 3,756,383.01	$ 3,561,787.69
8	548GF	Okeechobee	1	Okeechobee	FL	C	$ 3,315,087.30	$ 2,843,592.23
8	573BY	Jacksonville	1	Jacksonville	FL	L	$ 52,495,930.16	$ 44,533,104.83
8	573GA	Valdosta	1	Valdosta	GA	L	$ 5,341,783.04	$ 5,039,990.76
8	573GD	Ocala	1	Ocala	FL	L	$ 10,700,531.31	$ 8,261,402.40
8	573GE	St. Augustine	1	St. Augustine	FL	L	$ 6,111,125.68	$ 4,935,470.56
8	573GF	Tallahassee	1	Tallahassee	FL	L	$ 33,410,123.57	$ 27,019,226.16
8	573GG	Lecanto	1	Lecanto	FL	L	$ 10,045,827.07	$ 7,093,430.66
8	573GI	The Villages-Sumter County, FL	1	The Villages	FL	L	$ 5,590,326.31	$ 4,733,473.04
8	573GJ	St. Marys	1	St. Marys	GA	V	$ 3,953.72	$ 1,958,039.00
8	573GK	Marianna	1	Marianna	FL	V	$ 491,805.70	$ 2,544,023.72
8	672B0	Ponce	1	Ponce	PR	L	$ 25,292,223.84	$ 21,001,097.07
8	672BZ	Mayaguez	1	Mayaguez	PR	L	$ 25,997,539.44	$ 21,196,159.09
8	672GA	St Croix	1	St. Croix	VI	L	$ 1,107,015.10	$ 1,104,537.69
8	672GB	St Thomas	1	St. Thomas	VI	L	$ 534,682.21	$ 476,163.89
8	672GC	Arecibo	1	Arecibo	PR	L	$ 3,217,933.37	$ 2,156,587.10
8	672GE	Guayama	1	Guayama	PR	L	$ 786,117.80	$ 656,800.69
8	673BZ	New Port Richey	1	New Port Richey	FL	L	$ 31,519,544.65	$ 35,640,503.95
8	673GB	Lakeland	1	Lakeland	FL	L	$ 4,307,000.90	$ 5,822,513.68
8	673GC	Brooksville	1	Brooksville	FL	L	$ 5,314,214.49	$ 5,229,033.77
8	673GF	Zephyrhills	1	Zephyrhills	FL	L	$ 3,112,418.47	$ 3,339,063.20
8	675	Orlando	1	Orlando	FL	V	$ 102,779,362.09	$ 87,979,405.43
8	675GA	Viera	1	Viera	FL	V	$ 43,440,502.94	$ 36,349,767.19
8	675GB	Daytona Beach	2	Daytona Beach	FL	L	$ 21,647,294.65	$ 23,688,868.96
8	675GC	Kissimmee	1	Kissimmee	FL	L	$ 2,646,892.45	$ 2,531,782.70
8	675GD	Orange City	1	Sanford	FL	L	$ 2,284,808.04	$ 2,014,647.68
8	675GE	Leesburg (Lake County)	1	Leesburg	FL	L	$ 4,404,388.54	$ 4,291,869.71
9	581GA	Prestonsburg	1	Prestonsburg	KY	L	$ 2,742,709.62	$ 2,731,465.28
9	581GB	Charleston	1	Charleston	WV	L	$ 3,593,865.33	$ 3,470,309.40

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9	581GD	Williamson (Mingo County)	1	Williamson	WV	C	$ 227,054.17	$ 218,490.05
9	581GE	Logan County WV	1	Logan	WV	C	$ 268,666.61	$ 221,519.60
9	596	Lexington-Leestown	1	Lexington	KY	V	$ 39,903,682.94	$ 41,074,438.54
9	596GA	Somerset	1	Somerset	KY	L	$ 3,761,585.40	$ 3,985,274.63
9	596GB	Morehead	1	Morehead	KY	L	$ 1,074,898.18	$ 1,785,886.89
9	596GC	Hazard/Perry County	1	Hazard	KY	V	$ 217,118.31	$ 1,403,801.03
9	596GD	Berea	1	Berea	KY	L	N/A	$ 1,194,629.67
9	603GA	Fort Knox	1	Fort Knox	KY	L	$ 3,063,189.42	$ 2,381,883.48
9	603GB	New Albany IN (Southern Indiana)	1	New Albany	IN	L	$ 5,413,571.02	$ 4,990,720.57
9	603GC	Shively (Louisville-Jefferson County)	1	Louisville	KY	L	$ 5,329,823.32	$ 4,779,883.05
9	603GD	Dupont	1	Louisville	KY	L	$ 6,804,927.33	$ 5,834,207.06
9	603GE	Newburg	1	Louisville	KY	L	$ 6,165,470.27	$ 5,589,775.35
9	603GF	Grayson County	1	Clarkson	KY	V	$ 130,378.85	$ 2,785,484.08
9	603GG	Scott County	1	Scottsburg	IN	L	$ 474.74	$ 1,632,735.39
9	603GH	Carroll County	1	Carrollton	KY	L	$ 766.70	$ 947,810.05
9	614GA	Smithville	3	Smithville	MS	C	$ 2,297,024.78	$ 1,631,153.13
9	614GB	Jonesboro	1	Jonesboro	AR	C	$ 2,028,185.23	$ 1,498,502.10
9	614GC	Byhalia (Marshall County)	1	Byhalia	MS	C	$ 564,659.34	$ 429,565.66
9	614GD	Savannah (Hardin County)	1	Savannah	TN	C	$ 836,522.57	$ 755,543.31
9	614GE	Covington	1	Memphis	TN	V	$ 4,601,580.15	$ 4,004,091.26
9	614GF	Memphis-South Clinic	1	Memphis	TN	V	$ 5,610,669.74	$ 5,151,902.68
9	614GG	Jackson	1	Jackson	TN	L	N/A	$ 654,086.52
9	614GH	Bolivar	1	Bolivar	TN	C	N/A	$ 20,950.98
9	614GI	Dyersburg	1	Dyersburg	TN	L	N/A	N/A
9	614GN	Helena	1	Helena	AR	C	N/A	N/A
9	621BY	Knoxville	1	Knoxville	TN	L	$ 8,082,170.34	$ 9,734,225.18
9	621GA	Rogersville	6	Rogersville	TN	C	$ 268,299.85	$ 2,817.73
9	621GB	Mountain City	1	Mountain City	TN	C		
9	621GC	Norton	1	Norton	VA	C	$ 152,382.97	$ 244,257.64
9	621GD	St. Charles	10	Pennington Gap	VA	C	$ 1,598,603.81	$ 1,377,786.37
9	621GG	Morristown	1	Morristown	TN	V	$ 257,835.29	$ 1,128,004.45
9	621GJ	Bristol	1	Bristol	VA	L	N/A	$ 745,795.18
9	626GA	Dover	1	Dover	TN	C	$ 229,651.85	$ 436,252.58
9	626GC	Bowling Green	1	Bowling Green	KY	C	$ 1,505,465.28	$ 1,462,498.83
9	626GD	Ft. Campbell	1	Ft. Campbell	KY	L	$ 1,883,624.05	$ 1,711,885.58
9	626GE	Clarksville	1	Clarksville	TN	L	$ 2,220,927.33	$ 2,394,213.09
9	626GF	Chattanooga	1	Chattanooga	TN	L	$ 21,954,825.39	$ 18,289,762.66
9	626GG	Tullahoma	1	Arnold AFB	TN	L	$ 1,669,513.19	$ 1,463,333.32
9	626GH	Cookeville	1	Cookeville	TN	C	$ 2,514,791.23	$ 891,671.77

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9	626GI	Vine Hill	1	Nashville	TN	C	$ 378,503.55	$ 149,851.11
9	626GJ	Hopkinsville (Christian County)	1	Hopkinsville	KY	C	N/A	$ 147,168.97
9	626GK	McMinnville	1	McMinnville	TN	C	N/A	$ 147,308.24
10	538GA	Athens	1	Athens	OH	L	$ 2,660,505.12	$ 3,080,555.11
10	538GB	Portsmouth	1	Portsmouth	OH	L	$ 2,327,159.44	$ 3,360,843.07
10	538GC	Marietta	1	Marietta	OH	L	$ 1,788,537.53	$ 1,792,067.47
10	538GD	Lancaster	1	Lancaster	OH	L	$ 2,851,041.02	$ 3,015,009.29
10	538GE	Cambridge	1	Cambridge	OH	L	$ 1,877,347.80	$ 2,087,990.75
10	539GA	Bellevue	1	Bellevue	KY	L	$ 3,018,007.55	$ 3,552,952.97
10	539GB	Cincinnati (Clermont County)	1	Cincinnati	OH	L	$ 4,025,677.31	$ 4,203,205.40
10	539GC	Lawrenceburg (Dearborn County)	1	Greendale	IN	L	$ 3,010,140.27	$ 3,269,463.28
10	539GD	Florence	1	Florence	KY	L	$ 2,750,146.69	$ 3,427,571.04
10	539GE	Hamilton	1	Hamilton	OH	L	$ 2,447,024.94	$ 2,390,831.80
10	541BY	Canton	1	Canton	OH	L	$ 21,991,574.05	$ 17,352,432.33
10	541BZ	Youngstown	1	Youngstown	OH	L	$ 17,624,307.43	$ 16,467,575.96
10	541GB	Lorain	1	Lorain	OH	L	$ 11,104,498.50	$ 10,579,828.24
10	541GC	Sandusky	1	Sandusky	OH	L	$ 3,975,861.87	$ 3,654,998.54
10	541GD	Mansfield	1	Mansfield	OH	L	$ 6,555,563.68	$ 6,115,989.68
10	541GE	McCafferty	1	Cleveland	OH	L	$ 1,987,089.42	$ 1,859,050.78
10	541GF	Painesville	2	Painesville	OH	L	$ 4,548,879.83	$ 4,621,281.63
10	541GG	Akron	1	Akron	OH	L	$ 17,739,743.95	$ 16,467,111.16
10	541GH	East Liverpool	1	Calcutta	OH	L	$ 2,123,495.26	$ 2,124,378.71
10	541GI	Warren	1	Warren	OH	L	$ 3,416,783.66	$ 3,225,236.82
10	541GJ	New Philadelphia	1	New Philadelphia	OH	L	$ 1,974,571.31	$ 1,886,666.56
10	541GK	Ravenna	1	Ravenna	OH	L	$ 1,938,746.22	$ 1,870,188.21
10	552GA	Middletown	1	Middletown	OH	L	$ 1,885,081.04	$ 2,016,507.17
10	552GB	Lima	1	Lima	OH	L	$ 3,265,504.74	$ 2,865,095.30
10	552GC	Richmond	1	Richmond	IN	L	$ 1,907,452.44	$ 2,245,138.35
10	552GD	Springfield	1	Springfield	OH	L	$ 3,391,813.28	$ 2,714,832.56
10	757GA	Zanesville	1	Zanesville	OH	L	$ 3,730,366.69	$ 2,339,251.99
10	757GB	Grove City (Franklin County)	1	Grove City	OH	L	$ 2,661,240.26	$ 2,436,004.38
10	757GC	Marion	1	Marion	OH	L	$ 1,333,593.30	$ 1,700,979.84
10	757GD	Newark	1	Newark	OH	L	$ 2,216,082.89	$ 2,508,567.44
11	506GA	Toledo	1	Toledo	OH	L	$ 21,961,399.49	$ 17,744,702.08
11	506GB	Flint (Genessee Co.)	1	Flint	MI	L	$ 1,321,139.44	$ 1,602,720.49
11	506GC	Jackson	1	Jackson	MI	L	$ 2,502,962.43	$ 2,231,844.20
11	515BY	Grand Rapids	1	Grand Rapids	MI	L	$ 34,846,700.10	$ 31,075,028.79
11	515GA	Muskegon	1	Muskegon	MI	L	$ 1,981,617.46	$ 1,898,835.71
11	515GB	Lansing	1	Lansing	MI	L	$ 2,454,507.74	$ 2,441,013.66
11	515GC	Benton Harbor	1	Benton Harbor	MI	C	$ 2,140,638.09	$ 1,902,794.18
11	550BY	Peoria	1	Peoria	IL	L	$ 24,099,567.41	$ 22,662,283.12

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Data Source: VAST DSS

Operational CBOCs in FY Annual Costs

VISN	Station Number	Station Name	# of Sites	Location/City	ST	Clinic Operation Type L = lease (in-house) C = Contract V = VA owned (in house)	DSS FY08 Total Cost	DSS FY09 YTD Total Cost Through FP11
11	550GA	Decatur	1	Decatur	IL	L	$ 3,093,494.86	$ 3,011,420.40
11	550GC	Lafayette	1	West Lafayette	IN	L	$ 1,922,612.96	$ 2,216,149.27
11	550GD	Springfield	1	Springfield	IL	L	$ 2,495,692.72	$ 2,524,350.70
11	553GA	Yale	1	Yale	MI	C	$ 3,246,994.96	$ 2,702,614.98
11	553GB	Pontiac	1	Pontiac	MI	C	$ 3,257,563.18	$ 3,149,595.76
11	583GA	Terre Haute	1	Terre Haute	IN	C	$ 3,085,566.32	$ 1,353,066.56
11	583GB	Bloomington	1	Bloomington	IN	C	$ 2,769,819.68	$ 1,407,571.15
11	610GA	South Bend	1	South Bend	IN	C	$ 5,058,895.96	$ 2,784,544.70
11	610GB	Muncie	1	Muncie	IN	L	$ 4,909,563.58	$ 3,233,324.12
11	610GC	Goshen	1	Goshen	IN	C	N/A	$ 1,812,938.87
11	655GA	Gaylord	1	Gaylord	MI	L	$ 3,010,297.24	$ 3,426,149.73
11	655GB	Traverse City	1	Traverse City	MI	L	$ 3,117,413.40	$ 3,972,482.13
11	655GC	Oscoda	1	Oscoda	MI	L	$ 1,520,890.48	$ 1,410,770.60
11	655GD	Alpena County	1	Alpena	MI	V	N/A	$ 1,885,987.10
11	655GE	Clare	1	Clare	MI	L	N/A	$ 267,921.01
12	537BY	Adams Benjamin Jr. (Crown Point IN)	1	Crown Point	IN	L	$ 26,602,954.58	$ 22,971,610.69
12	537GA	Chicago Heights	1	Chicago Heights	IL	L	$ 1,520,548.45	$ 1,347,171.30
12	537GD	Chicago HCS (Lakeside Division)	1	Chicago	IL	V	$ 9,165,837.76	$ 5,874,356.41
12	537HA	Woodlawn (Beverly)	1	Chicago	IL	L	$ 2,158,203.94	$ 1,244,161.50
12	556GA	Evanston	1	Evanston	IL	L	$ 1,192,336.20	$ 1,275,214.39
12	556GC	McHenry	1	McHenry	IL	L	$ 1,461,698.08	$ 1,495,649.95
12	556GD	Kenosha County	1	Kenosha	WI	V	$ 1,256,759.37	$ 1,558,295.63
12	578GA	Joliet	1	Joliet	IL	L	$ 4,200,109.44	$ 3,944,555.07
12	578GC	Manteno	1	Manteno	IL	L	$ 2,350,924.91	$ 2,317,287.32
12	578GD	Aurora IL	1	Aurora	IL	L	$ 2,643,718.82	$ 2,175,695.49
12	578GE	Elgin	1	Elgin	IL	L	$ 2,700,529.21	$ 2,491,189.03
12	578GF	Lasalle	1	LaSalle	IL	L	$ 3,444,166.54	$ 3,593,397.40
12	578GG	Oak Lawn	1	Oak Lawn	IL	L	$ 2,491,054.00	$ 2,918,610.39
12	585GA	Hancock	1	Hancock	MI	L	$ 1,521,265.63	$ 1,366,932.28
12	585GB	Rhinelander	1	Rhinelander	WI	L	$ 2,885,707.92	$ 2,299,986.53
12	585GC	Menominee MI	1	Menominee	MI	L	$ 2,012,113.04	$ 1,753,290.67
12	585GD	Ironwood	1	Ironwood	MI	L	$ 1,192,634.68	$ 1,227,680.77
12	585HA	Marquette MI	1	Marquette	MI	L	$ 1,916,602.51	$ 2,567,301.71
12	585HB	Sault Ste. Marie	1	Kincheloe	MI	L	$ 1,641,109.39	$ 1,663,041.33
12	607GC	Janesville	1	Janesville	WI	L	$ 1,931,761.27	$ 2,355,611.59
12	607GD	Baraboo	1	Baraboo	WI	V	$ 1,044,899.40	$ 1,165,399.59
12	607GE	Beaver Dam	1	Beaver Dam	WI	V	$ 1,389,801.56	$ 1,351,957.88
12	607GF	Freeport	1	Freeport	IL	L	$ 1,355,326.44	$ 1,230,239.13
12	607HA	Rockford	1	Rockford	IL	L	$ 9,193,482.70	$ 8,256,981.72
12	676GA	Wausau	1	Wausau	WI	L	$ 2,311,549.26	$ 2,950,508.94
12	676GC	La Crosse	1	La Crosse	WI	L	$ 4,255,547.53	$ 5,296,621.39
12	676GD	Wisconsin Rapids	1	Wisconsin Rapids	WI	C	$ 2,353,196.22	$ 2,311,748.38
12	676GE	Loyal WI	1	Loyal	WI	L	$ 399,902.02	$ 396,624.75

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12	695BY	Appleton	1	Appleton	WI	L	$ 19,497,950.95	$ 18,074,776.69
12	695GA	Union Grove WI	1	Union Grove	WI	L	$ 3,946,593.18	$ 3,524,329.62
12	695GC	Cleveland	1	Cleveland	WI	L	$ 4,505,041.39	$ 4,082,895.82
12	695GD	Milo C. Huempfner VA Outpatient Clinic (Green Bay)	1	Green Bay	WI	L	$ 2,929,422.69	$ 3,084,788.50
15	589G1	Warrensburg	1	Warrensburg	MO	L	$ 993,429.89	$ 909,895.48
15	589G2	Dodge City	1	Ft. Dodge	KS	L	$ 658,785.37	$ 624,499.84
15	589G3	Liberal	1	Liberal	KS	L	$ 188,039.76	$ 256,396.92
15	589G4	Hays	1	Hays	KS	L	$ 1,290,390.02	$ 1,178,416.02
15	589G5	Parsons	1	Parsons	KS	L	$ 1,103,758.14	$ 938,274.60
15	589G7	Hutchinson	1	Hutchinson	KS	L	$ 404,740.09	$ 1,374,971.60
15	589G8	Jefferson City	1	Jefferson City	MO	L	$ 49,637.39	$ 955,072.93
15	589G9	Fort Riley	1	Fort Riley	KS	L	N/A	$ 368,209.13
15	589GB	Belton	1	Belton	MO	L	$ 938,895.22	$ 911,116.57
15	589GC	Louisburg-Paola	1	Paola	KS	L	$ 742,706.65	$ 579,892.47
15	589GD	Nevada	1	Nevada	MO	L	$ 987,304.49	$ 1,130,205.33
15	589GE	Kirksville	1	Kirksville	MO	C	$ 1,171,853.60	$ 2,672,856.18
15	589GF	Ft Leonard Wood MO	1	Ft. Leonard Wood	MO	L	$ 1,541,291.21	$ 943,862.23
15	589GH	Lake of the Ozarks/Camdenton	1	Camdenton	MO	L	$ 3,175,107.76	$ 1,420,657.37
15	589GI	St. Joseph	1	St. Joseph	MO	L	$ 1,416,790.89	$ 1,472,351.08
15	589GJ	Wyandotte Co	1	Kansas City	KS	L	$ 1,207,154.78	$ 1,044,701.60
15	589GM	Chanute	1	Chanute	KS	L	$ 277,556.38	$ 210,546.75
15	589GN	Emporia	1	Emporia	KS	L	$ 105,261.71	$ 169,865.60
15	589GP	Garnett	1	Garnett	KS	L	$ 104,969.00	$ 84,608.67
15	589GQ	Holton	1	Holton	KS	L	$ 59,433.76	$ 50,523.88
15	589GR	Junction City	1	Junction City	KS	L	$ 1,126,702.78	$ 822,314.70
15	589GT	Seneca	1	Seneca	KS	L	$ 69,290.42	$ 55,790.91
15	589GU	Lawrence	1	Lawrence	KS	L	$ 636,627.79	$ 381,526.95
15	589GV	Ft. Scott (Bourbon Co.)	1	Ft. Scott	KS	L	$ 437,384.35	$ 566,476.05
15	589GW	Salina	1	Salina	KS	L	$ 1,386,991.63	$ 1,028,026.10
15	589GX	Mexico	1	Mexico	MO	L	$ 1,081,721.40	$ 545,584.48
15	589GY	St. James	1	St. James	MO	L	$ 1,019,767.66	$ 534,453.94
15	589GZ	Cameron	1	Cameron	MO	L	$ 774,013.93	$ 647,111.66
15	657GA	Belleville	1	Belleville	IL	L	$ 1,695,531.61	$ 1,258,220.99
15	657GB	St. Louis CBOC	1	St. Louis	MO	L	$ 1,209,911.48	$ 826,604.42
15	657GD	St. Charles County	1	St. Charles	MO	L	$ 1,051,493.53	$ 922,179.66
15	657GF	West Plains	1	West Plains	MO	L	$ 1,881,716.59	$ 1,960,518.81
15	657GG	Paragould	1	Paragould	AR	V	$ 1,542,712.96	$ 1,464,019.92
15	657GH	Cape Girardeau	1	Cape Girardeau	MO	L	$ 2,177,156.54	$ 2,378,638.13
15	657GI	Farmington	1	Farmington	MO	L	$ 1,581,502.51	$ 1,671,222.62
15	657GJ	Evansville	1	Evansville	IN	L	$ 18,250,714.76	$ 22,812,388.36
15	657GK	Mt. Vernon	1	Mt. Vernon	IL	L	$ 1,173,125.77	$ 1,254,398.92

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15	657GL	Paducah	1	Paducah	KY	L	$ 3,696,797.65	$ 3,235,616.69
15	657GM	Effingham	1	Effingham	IL	L	$ 2,269,412.04	$ 1,972,140.71
15	657GN	Salem	1	Salem	MO	V	$ 49,351.85	$ 54,077.04
15	657GO	Hanson (Hopkins County), KY	1	Hanson	KY	L	$ 569,036.03	$ 471,895.60
15	657GP	Owensboro	1	Owensboro	KY	L	$ 49,528.48	$ 902,744.31
15	657GQ	Vincennes	1	Vincennes	IN	L	$ 4,723.67	$ 594,193.15
15	657GR	Mayfield	1	Mayfield	KY	L	N/A	$ 159,076.04
15	657GV	Sikeston	1	Sikeston	MO	L	N/A	N/A
16	502GA	Jennings	1	Jennings	LA	L	$ 4,651,234.84	$ 3,317,985.47
16	502GB	Lafayette	1	Lafayette	LA	L	$ 7,809,542.82	$ 6,085,165.46
16	520BZ	Joint Ambulatory Care Center	1	Pensacola	FL	V	$ 32,550,336.04	$ 35,565,622.98
16	520GA	Mobile	1	Mobile	AL	L	$ 13,224,927.49	$ 12,132,889.41
16	520GB	Panama City	1	Panama City Beach	FL	L	$ 5,150,076.09	$ 5,280,412.89
16	520GC	Eglin AFB	1	Eglin AFB	FL	V	$ 870,437.63	$ 3,480,600.95
16	564BY	Gene Taylor	1	Mt. Vernon	MO	L	$ 17,645,843.27	$ 15,656,792.54
16	564GA	Harrison	1	Harrison	AR	C	$ 1,504,369.22	$ 1,090,049.24
16	564GB	Ft. Smith	1	Ft. Smith	AR	L	$ 8,732,261.07	$ 8,439,694.73
16	564GC	Branson	1	Branson	MO	L	$ 18,239.98	$ 1,924,048.13
16	580BY	Beaumont	1	Beaumont	TX	L	$ 10,896,339.34	$ 14,604,172.04
16	580BZ	Lufkin	1	Lufkin	TX	L	$ 8,954,340.16	$ 12,336,244.61
16	580GC	Galveston County	1	Texas City	TX	C	$ 5,496,181.09	$ 1,137,938.08
16	580GD	Conroe	1	Conroe	TX	L	$ 3,947,522.63	$ 3,291,222.07
16	586GA	Durant (Kosciusko)	1	Kosciusko	MS	C	$ 955,100.64	$ 993,351.28
16	586GB	Meridian	1	Meridian	MS	C	$ 2,090,450.71	$ 1,597,386.38
16	586GC	Greenville	1	Greenville	MS	C	$ 1,368,190.37	$ 1,390,425.64
16	586GD	Hattiesburg	1	Hattiesburg	MS	C	$ 2,320,722.30	$ 1,899,671.54
16	586GE	Natchez (Adams County)	2	Natchez	MS	C	$ 1,325,289.93	$ 1,245,121.26
16	586GF	Columbus	1	Columbus	MS	C	$ 2,120,447.01	$ 1,954,408.95
16	598GA	Mountain Home	1	Mountain Home	AR	C	$ 2,037,641.15	$ 2,200,408.73
16	598GB	Eldorado	1	Eldorado	AR	C	$ 1,989,413.50	$ 1,413,856.46
16	598GC	Hot Springs	1	Hot Springs	AR	C	$ 2,076,828.90	$ 2,132,269.58
16	598GD	Mena	1	Mena	AR	C	$ 1,022,619.35	$ 1,347,072.89
16	598GE	Pine Bluff	1	Pine Bluff	AR	C	$ 528,136.16	$ 1,126,753.79
16	598GF	Searcy	1	Searcy	AR	L	N/A	N/A
16	623BY	Tulsa	2	Tulsa	OK	L	$ 21,055,723.83	$ 20,915,049.02
16	623GA	Hartshorne	1	Hartshorne	OK	L	$ 594,756.56	$ 817,061.82
16	629BY	Baton Rouge	1	Baton Rouge	LA	L	$ 19,538,003.51	$ 20,261,145.41
16	629GA	Houma	1	Houma	LA	C	$ 2,566,519.61	$ 984,759.05
16	629GB	Hammond	1	Hammond	LA	V	$ 5,475,077.97	$ 4,171,101.83
16	629GC	Slidell	1	Slidell	LA	L	$ 5,181,548.32	$ 4,592,426.06
16	629GD	St. Johns	1	Reserve	LA	V	$ 4,917,990.75	$ 3,838,889.15
16	635GA	Lawton	1	Ft. Sill	OK	V	$ 11,469,404.29	$ 10,477,083.60

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16	635GB	Wichita Falls	1	Wichita Falls	TX	C	$ 1,814,558.39	$ 1,953,962.16
16	635GC	Ponca City	1	Blackwell	OK	C	$ 336,129.26	$ 383,900.58
16	635GD	Konawa/Seminole County	1	Konawa	OK	C	$ 585,770.64	$ 895,857.38
16	635GE	Stillwater	1	Stillwater	OK	C	N/A	N/A
16	635GF	Altus	1	Altus	OK	C	N/A	N/A
16	635GG	Enid	1	Enid	OK	C	N/A	N/A
16	635HA	Clinton	1	Clinton	OK	L		
16	635HB	Ardmore	1	Ardmore	OK	L	$ 255,552.65	$ 524,751.66
16	667GA	Texarkana	1	Texarkana	AR	L	$ 3,349,571.59	$ 3,185,711.33
16	667GB	Monroe	1	Monroe	LA	L	$ 3,633,125.02	$ 3,065,232.48
16	667GC	Longview	1	Longview	TX	L	$ 3,310,819.48	$ 3,348,887.94
17	549A4	Bonham VAMC	1	Bonham	TX	V	$ 19,629,807.34	$ 17,722,962.13
17	549BY	Fort Worth Satellite	1	Fort Worth	TX	L	$ 19,988,205.83	$ 18,458,222.79
17	549GA	Tyler	1	Tyler	TX	L	$ 1,957,982.45	$ 1,742,227.85
17	549GB	Dallas County Primary Care Network	1	Dallas	TX	C	$ 7,290.43	
17	549GC	Bonham Area Primary Care Network	1	Paris	TX	C	$ 1,045,529.78	$ 318,965.06
17	549GD	Denton Area Primary Care Network	1	Denton	TX	C	$ 3,828,334.39	$ 3,607,900.29
17	549GE	Decatur Area Primary Care Network	1	Bridgeport	TX	C	$ 398,236.20	$ 605,841.60
17	549GF	Eastland Area Primary Care Network	1	Granbury	TX	C	$ 385,112.82	$ 498,715.75
17	549GH	Greenville Area PCN	1	Greenville	TX	C	$ 223,425.90	$ 536,727.83
17	549GI	Cleburne Area PCN	1	Waxahachie	TX	C		
17	549GJ	Sherman	1	Sherman	TX	C	$ 365,431.44	$ 1,813,671.72
17	549HA	Tarrant County Primary Care Network	1	Fort Worth	TX	C	$ 248,323.78	$ 411,367.85
17	671B0	McAllen Satellite	1	McAllen	TX	L	$ 16,018,376.16	$ 16,488,143.48
17	671BY	Frank M. Tejeda Satellite	1	San Antonio	TX	L	$ 35,050,538.61	$ 31,634,773.24
17	671BZ	Corpus Christi Satellite	1	Corpus Christi	TX	V	$ 19,156,551.93	$ 18,088,808.33
17	671GA	Harlingen	1	Harlingen	TX	L	$ 13,473,740.19	$ 18,653,617.08
17	671GB	Victoria	1	Victoria	TX	L	$ 2,649,471.83	$ 2,299,661.01
17	671GD	Eagle Pass	1	Eagle Pass	TX	C	$ 174,111.84	$ 248,391.21
17	671GE	Laredo	1	Laredo	TX	L	$ 3,459,836.00	$ 3,484,791.22
17	671GF	South Bexar Cnty	1	San Antonio	TX	L	$ 1,417,181.38	$ 1,455,184.12
17	671GG	Alice	1	San Diego	TX	C		
17	671GH	Beeville	1	Beeville	TX	C	$ 202,069.03	$ 666,863.09
17	671GI	Kingsville	1	Kingsville	TX	C	$ 123,311.57	N/A
17	671GJ	Uvalde	1	Uvalde	TX	C	N/A	$ 29,731.41

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17	671GK	San Antonio Area PCN	4	San Antonio	TX	C	$ 1,430,090.44	$ 3,626,339.73
17	671GL	New Braunfels (Comal County)	1	New Braunfels	TX	C	$ 412,376.66	$ 1,074,934.36
17	671GN	Seguin (Guadalupe County)	1	Seguin	TX	C	$ 93,966.09	$ 398,282.45
17	671GO	San Antonio, TX	1	San Antonio	TX	V	$ 12,604,740.74	$ 10,514,596.83
17	674BY	Austin Satellite	1	Austin	TX	L	$ 40,420,645.58	$ 38,492,988.36
17	674GA	Palestine	1	Palestine	TX	L	$ 3,110,128.75	$ 3,097,313.04
17	674GB	Brownwood	1	Brownwood	TX	L	$ 3,728,414.09	$ 3,405,473.64
17	674GC	College Station (Bryan)	1	College Station	TX	L	$ 4,010,316.24	$ 3,677,611.62
17	674GD	Cedar Park	1	Cedar Park	TX	L	$ 3,420,097.08	$ 4,380,247.85
18	501G2	Las Vegas	6	Las Vegas	NM	C	$ 1,035,437.06	$ 679,242.26
18	501GA	Artesia	1	Artesia	NM	L	$ 1,815,680.83	$ 1,685,754.63
18	501GB	Farmington	1	Farmington	NM	L	$ 1,773,990.94	$ 1,563,033.87
18	501GC	Silver City	1	Silver City	NM	L	$ 1,381,987.15	$ 1,236,714.92
18	501GD	Gallup NM	1	Gallup	NM	L	$ 1,524,001.98	$ 1,402,058.12
18	501GE	Espanola	6	Espanola	NM	C	$ 1,557,492.72	$ 1,193,044.24
18	501GH	Truth or Consequences	1	Truth or Consequences	NM	C	$ 445,549.67	$ 478,910.58
18	501GI	Alamogordo	1	Alamogordo	NM	C	$ 681,955.65	$ 532,168.48
18	501GJ	Durango	1	Durango	CO	C	$ 1,769,704.94	$ 1,002,169.78
18	501GK	Santa Fe	1	Sante Fe	NM	L	$ 1,837,990.84	$ 1,897,535.28
18	501HB	Raton	1	Raton	NM	L	$ 1,274,685.66	$ 1,345,018.69
18	504BY	Lubbock TX	1	Lubbock	TX	L	$ 16,518,510.73	$ 14,897,870.93
18	504BZ	Clovis	1	Clovis	NM	L	$ 1,753,634.81	$ 1,779,703.61
18	504GA	Childress	1	Childress	TX	C	$ 634,990.51	$ 417,654.25
18	504HB	Stratford	1	Stratford	TX	C	$ 270,737.77	$ 121,459.33
18	519GA	Odessa	1	Odessa	TX	L	$ 2,276,854.86	$ 2,705,897.01
18	519GB	Hobbs	1	Hobbs	NM	L	$ 982,740.74	$ 920,054.19
18	519GD	Ft Stockton	1	Ft. Stockton	TX	C	$ 184,149.48	$ 206,151.03
18	519HC	Abilene TX	1	Abilene	TX	L	$ 2,650,189.71	$ 3,189,323.07
18	519HD	Stamford	1	Stamford	TX	L	$ 126,295.58	$ 138,218.93
18	519HF	San Angelo	1	San Angelo	TX	L	$ 2,095,454.90	$ 2,319,857.40
18	644BY	Mesa	1	Mesa	AZ	L	$ 11,134,150.93	$ 9,712,185.02
18	644GA	Sun City	1	Sun City	AZ	L	$ 5,749,118.79	$ 4,908,027.62
18	644GB	Show Low	1	Show Low	AZ	L	$ 2,961,123.23	$ 2,575,886.72
18	644GC	Buckeye	1	Buckeye	AZ	C	$ 588,851.49	$ 476,236.44
18	644GD	Payson (Gila County)	1	Payson	AZ	C	$ 476,362.01	$ 387,648.97
18	644GE	Thunderbird	1	Phoenix	AZ	L	N/A	$ 741,858.59
18	644GF	Globe	1	Globe	AZ	V	$ 449,763.42	$ 561,398.57
18	649GA	Kingman	1	Kingman	AZ	L	$ 2,495,149.70	$ 2,411,100.62
18	649GB	Bellemont	1	Bellemont	AZ	L	$ 980,760.31	$ 784,049.85
18	649GC	Lake Havasu	1	Lake Havasu City	AZ	L	$ 2,208,652.64	$ 2,066,479.56

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Data Source: VAST DSS

Operational CBOCs in FY Annual Costs

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18	649GD	Anthem	1	Anthem	AZ	L	$ 1,692,979.47	$ 1,435,531.46
18	649GE	Cottonwood (Yavapai County)	1	Cottonwood	AZ	L	$ 1,727,757.47	$ 1,633,703.63
18	678GA	Sierra Vista	1	Sierra Vista	AZ	L	$ 3,595,145.07	$ 3,775,886.74
18	678GB	Yuma	1	Yuma	AZ	L	$ 3,043,306.85	$ 2,853,169.10
18	678GC	Casa Grande	1	Casa Grande	AZ	L	$ 1,797,802.80	$ 2,467,445.95
18	678GD	Safford	1	Safford	AZ	L	$ 776,963.63	$ 767,988.71
18	678GE	Green Valley	1	Green Valley	AZ	L	$ 1,221,704.39	$ 965,273.47
18	678GF	NW Tucson Urban 1	1	Tucson	AZ	L	$ 2,962,307.34	$ 3,827,913.79
18	678GG	SE Tucson Urban 2	1	Tucson	AZ	L	$ 51,275.45	$ 2,751,644.99
18	756GA	Las Cruces	1	Las Cruces	NM	L	$ 1,952,206.02	$ 2,332,259.78
19	436GA	Anaconda	1	ANACONDA	MT	L	$ 1,136,781.31	$ 860,496.37
19	436GB	Great Falls	1	GREAT FALLS	MT	L	$ 2,503,596.53	$ 3,336,243.70
19	436GC	Missoula	1	MISSOULA	MT	L	$ 3,772,241.92	$ 3,791,577.29
19	436GD	Bozeman	1	BOZEMAN	MT	L	$ 1,210,701.79	$ 1,154,566.56
19	436GF	Kalispell	1	KALISPELL	MT	L	$ 3,275,272.25	$ 2,829,475.41
19	436GH	Billings	2	BILLINGS	MT	L	$ 10,765,583.19	$ 9,713,749.43
19	436GI	Glasgow	1	Glasgow	MT	C	$ 510,799.29	$ 328,198.15
19	436GJ	Miles City	1	Miles City	MT	V	$ 1,289,697.75	$ 845,534.66
19	436GK	Glendive Montana	1	Glendive	MT	L	$ 876,880.53	$ 705,232.98
19	436GL	Cut Bank	1	Cut Bank	MT	V	$ 131,730.06	$ 289,212.26
19	436GM	Lewiston	1	Lewistown	MT	V	$ 231,955.06	$ 951,548.32
19	442GB	Sidney	1	Sidney	NE	C	$ 88,892.57	$ 56,700.80
19	442GC	Fort Collins	1	FORT COLLINS	CO	L	$ 2,796,215.63	$ 2,245,823.10
19	442GD	Greeley	1	Greeley	CO	L	$ 2,473,049.86	$ 2,139,047.08
19	554GB	Aurora	1	AURORA	CO	L	$ 2,756,678.08	$ 2,750,975.63
19	554GC	Lakewood	1	Lakewood	CO	V	$ 1,829,677.78	$ 2,048,300.03
19	554GD	Pueblo	1	PUEBLO	CO	L	$ 16,454,825.68	$ 13,402,508.72
19	554GE	Colorado Springs	1	COLORADO SPRINGS	CO	L	$ 17,273,950.95	$ 16,832,479.86
19	554GF	Alamosa	1	Alamosa	CO	L	$ 1,499,576.46	$ 1,266,387.01
19	554GG	La Junta	1	La Junta	CO	L	$ 2,523,935.35	$ 1,977,145.32
19	554GH	Lamar	1	Lamar	CO	C	$ 252,754.41	$ 234,142.54
19	554GI	Burlington	1	Burlington	CO	V	$ 316,439.79	$ 221,712.80
19	575GA	Montrose	1	Montrose	CO	L	$ 854,800.97	$ 894,378.00
19	660GA	Pocatello	1	POCATELLO	ID	L	$ 2,928,128.87	$ 2,834,550.07
19	660GB	Ogden	1	South Ogden	UT	L	$ 2,776,310.89	$ 2,270,032.08
19	660GC	Ely	1	Ely	NV	C	$ 395,471.57	$ 463,651.22
19	660GD	Roosevelt	1	Roosevelt	UT	C	$ 578,653.92	$ 1,345,962.56
19	660GE	Orem	1	Orem	UT	L	$ 1,366,369.02	$ 1,004,033.61
19	660GG	St. George	1	St. George	UT	L	$ 1,990,106.32	$ 2,078,039.32
19	660GI	Nephi	2	Fountain Green	UT	C	$ 500,628.28	$ 714,418.46
19	660GJ	Western Salt Lake	1	West Valley City	UT	L	N/A	$ 2,651,538.93
19	666GB	Casper	1	CASPER	WY	L	$ 3,463,456.97	$ 2,970,991.64
19	666GC	Riverton	1	RIVERTON	WY	L	$ 2,057,501.31	$ 1,968,800.52

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19	666GD	Powell	1	Powell	WY	C	$ 1,907,514.73	$ 1,633,059.63
19	666GE	Gillette	1	Gillette	WY	L	$ 1,089,387.89	$ 995,960.94
19	666GF	Rock Springs	1	Rock Springs	WY	L	$ 2,031,088.27	$ 1,834,212.19
20	463GA	Fairbanks	1	Fort Wainwright	AK	L	$ 6,817,072.34	$ 3,102,770.89
20	463GB	Kenai	1	Kenai	AK	L	$ 3,915,220.96	$ 2,254,956.10
20	463GC	Mat-Su	1	Wasilla	AK	L	N/A	$ 399,093.95
20	531GE	Twin Falls	1	Twin Falls	ID	V	$ 2,045,748.80	$ 1,140,824.83
20	531GG	Canyon County	1	Caldwell	ID	L	$ 458,687.64	$ 778,934.18
20	648A4	Vancouver	1	Vancouver	WA	V	$ 58,645,854.83	$ 51,014,916.49
20	648GA	Bend	1	Bend	OR	L	$ 3,695,084.08	$ 4,210,384.61
20	648GB	Salem	1	Salem	OR	L	$ 4,087,239.99	$ 4,023,426.39
20	648GD	North Coast	1	Warrenton	OR	L	$ 839,986.99	$ 943,861.81
20	648GE	East Metro Portland	1	Portland	OR	L	$ 3,631,755.56	$ 3,850,999.52
20	648GF	West Metro Portland	1	Hillsboro	OR	L	N/A	$ 5,465,790.33
20	653BY	Eugene	2	Eugene	OR	L	$ 9,734,495.57	$ 8,844,219.72
20	653GA	North Bend	1	North Bend	OR	L	$ 3,031,216.17	$ 1,963,372.26
20	653GB	Brookings	1	Brookings	OR	L	$ 1,232,637.50	$ 797,817.07
20	663GA	King County	3	Bellevue	WA	C	$ 3,594,440.00	$ 2,864,617.45
20	663GB	Bremerton (Kitsap County)	1	Bremerton	WA	L	$ 2,979,736.44	$ 1,809,442.07
20	663GC	Mount Vernon	1	Mount Vernon	WA	L	$ 614,963.00	$ 714,265.26
20	668GA	NW Central Washington, WA	1	Wenatchee	WA	L	$ 2,832,105.95	$ 1,922,454.22
20	668GB	North Idaho	1	Coeur dAlene	ID	V	$ 678,640.17	$ 1,699,263.38
20	687GA	Richland WA	1	Richland	WA	L	$ 4,818,856.01	$ 2,673,995.86
20	687GB	Lewiston	1	Lewiston	ID	L	$ 1,452,608.52	$ 1,262,277.89
20	687GC	La Grande	1	La Grande	OR	L	$ 1,170,468.51	$ 1,146,031.96
20	687HA	Yakima	1	Yakima	WA	L	$ 5,328,288.85	$ 4,549,277.25
20	692	Southern Oregon Rehabilitation Ctr & Clinics	1	White City	OR	V	$ 37,961,379.14	$ 31,444,432.18
20	692GA	Klamath Falls	1	Klamath Falls	OR	L	$ 1,803,423.95	$ 2,038,819.51
21	459GA	Maui	2	Kahului	HI	L	$ 5,215,574.96	$ 3,785,226.61
21	459GB	Hilo	1	Hilo	HI	L	$ 4,618,543.36	$ 3,366,659.99
21	459GC	Kailua-Kona	1	Kailua-Kona	HI	L	$ 2,886,828.45	$ 2,388,827.25
21	459GD	Lihue	1	Lihue	HI	L	$ 2,630,748.15	$ 2,492,502.48
21	459GE	Guam	1	Agana Heights	GU	L	$ 2,355,677.93	$ 1,813,263.58
21	459GF	American Samoa	1	Pago Pago	AS	L	$ 1,860,006.91	$ 1,401,841.78
21	570GA	Atwater	1	Atwater	CA	L	$ 3,172,704.62	$ 2,723,764.83
21	570GB	Tulare	1	Tulare	CA	L	$ 2,504,769.17	$ 2,165,525.79
21	612B4	Redding	1	Redding	CA	L	$ 27,252,327.73	$ 23,350,316.40
21	612BY	Oakland	1	Oakland	CA	L	$ 25,399,137.94	$ 21,543,351.20
21	612GD	Fairfield	1	Travis AFB	CA	V	$ 7,592,493.81	$ 9,426,243.16
21	612GE	Vallejo/Mare Island	1	Mare Island	CA	V	$ 9,030,113.47	$ 7,051,238.32
21	612GF	Martinez	1	Martinez	CA	V	$ 72,878,832.87	$ 65,080,962.41

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21	612GG	Chico	1	Chico	CA	L	$ 10,168,253.04	$ 8,664,746.47
21	612GH	McClellan	1	McClellan Park	CA	V	$ 24,443,197.35	$ 21,448,060.39
21	640BY	San Jose	1	San Jose	CA	L	$ 21,509,075.30	$ 17,932,961.32
21	640GA	Palo Alto HCS- Capitola	1	Capitola	CA	L	$ 582,109.87	$ 467,333.20
21	640GB	Sonora (Tuolumne County)	1	Sonora	CA	C	$ 2,470,408.26	$ 2,153,340.83
21	640HA	Stockton	1	French Camp	CA	L	$ 6,389,410.09	$ 6,021,698.50
21	640HB	Modesto	1	Modesto	CA	L	$ 8,313,542.60	$ 7,262,210.78
21	640HC	Monterey	1	Seaside	CA	V	$ 15,218,849.69	$ 13,042,996.53
21	654GA	Sierra Foothills	1	Auburn	CA	L	$ 4,980,211.31	$ 4,017,095.06
21	654GB	Carson Valley	1	Minden	NV	L	$ 2,954,071.79	$ 1,915,008.41
21	654GC	Lahontan Valley	1	Fallon	NV	L	$ 770,762.49	$ 1,794,125.70
21	662GA	Santa Rosa	1	Santa Rosa	CA	L	$ 10,573,037.84	$ 7,372,999.71
21	662GC	Eureka	1	Eureka	CA	C	$ 5,773,119.16	$ 5,065,833.62
21	662GD	Ukiah	1	Ukiah	CA	L	$ 4,150,559.69	$ 4,382,074.83
21	662GE	San Bruno	1	San Bruno	CA	L	$ 1,486,748.80	$ 1,479,496.91
21	662GF	San Francisco	1	San Francisco	CA	L	$ 4,377,433.15	$ 4,812,711.20
22	593GA	Las Vegas Homeless	1	Las Vegas	NV	L	$ 1,096,253.66	$ 370,202.32
22	593GB	Henderson	1	Henderson	NV	C	$ 3,029,914.07	$ 2,714,791.69
22	593GC	Pahrump	1	Pahrump	NV	L	$ 3,383,811.20	$ 2,061,608.47
22	600GA	Anaheim	1	Anaheim	CA	L	$ 2,063,243.03	$ 2,251,072.07
22	600GB	Santa Ana	1	Santa Ana	CA	L	$ 3,245,222.13	$ 2,203,915.58
22	600GC	Cabrillo (Long Beach)	1	Long Beach	CA	L	$ 3,588,180.57	$ 2,513,116.84
22	600GD	Santa Fe Springs/Whittier	1	Santa Fe Springs	CA	C	$ 599,567.15	$ 2,564,254.03
22	600GE	Laguna Hills Veterans Health	1	Laguna Hills	CA	C	$ 2,142,149.92	$ 2,421,085.10
22	605GA	Victorville	1	Victorville	CA	C	$ 2,112,831.43	$ 1,875,894.69
22	605GB	Sun City	1	Sun City	CA	C	$ 2,015,053.89	$ 2,035,307.88
22	605GC	Palm Desert	1	Palm Desert	CA	C	$ 2,674,884.99	$ 3,079,999.82
22	605GD	Corona (Riverside County) CA	1	Corona	CA	C	$ 1,176,947.30	$ 1,133,405.27
22	605GE	Upland	1	Upland	CA	C	$ 1,412,890.06	$ 1,478,000.84
22	664BY	Mission Valley	1	San Diego	CA	L	$ 35,688,683.43	$ 30,562,254.89
22	664GA	Imperial Valley	1	El Centro	CA	C	$ 806,234.53	$ 1,404,676.81
22	664GB	Vista	1	Vista	CA	L	$ 6,904,678.83	$ 7,327,889.99
22	664GC	Chula Vista	1	Chula Vista	CA	L	$ 3,128,520.28	$ 2,992,764.95
22	664GD	Escondido	1	Escondido	CA	C	$ 2,863,848.67	$ 2,165,023.41
22	691A4	Sepulveda	1	Sepulveda	CA	V	$ 63,842,472.72	$ 58,452,984.96
22	691GA	Los Angeles	1	Los Angeles	CA	V		
22	691GB	Santa Barbara	1	Santa Barbara	CA	L	$ 6,216,973.41	$ 5,131,450.58
22	691GC	Gardena	1	Gardena	CA	L	$ 2,779,516.80	$ 2,326,581.82
22	691GD	Bakersfield	1	Bakersfield	CA	L	$ 11,311,596.53	$ 9,970,229.19
22	691GE	Los Angeles	1	Los Angeles	CA	V	$ 27,662,056.38	$ 25,182,101.14

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22	691GF	EAST LOS ANGELES CLINIC	1	City of Commerce	CA	L	$ 2,806,476.05	$ 2,282,913.42
22	691GG	Antelope Valley	1	Lancaster	CA	C	$ 2,553,181.97	$ 2,111,611.43
22	691GK	San Luis Obispo	1	San Luis Obispo	CA	L	$ 1,435,803.71	$ 1,639,387.86
22	691GL	Santa Maria	1	Santa Maria	CA	L	$ 3,761,319.49	$ 4,033,587.82
22	691GM	Port Hueneme (Oxnard)	1	Oxnard	CA	C	$ 3,645,618.26	$ 3,013,883.08
22	691GN	South Central LA	1	Lynwood	CA	V		
22	691GO	Pasadena	1	San Gabriel	CA	C	$ 757,937.25	$ 595,960.30
23	437GA	Grafton	1	Grafton	ND	L	$ 1,340,581.30	$ 701,334.92
23	437GB	Bismarck ND	1	Bismarck	ND	L	$ 2,948,968.81	$ 2,089,793.99
23	437GC	Fergus Falls	1	Fergus Falls	MN	L	$ 939,196.08	$ 682,019.65
23	437GD	Minot	1	Minot	ND	L	$ 1,529,205.70	$ 1,233,576.67
23	437GE	Bemidji	1	Bemidji	MN	L	$ 1,397,242.20	$ 1,817,442.36
23	437GF	Williston	1	Williston	ND	C	$ 800,129.79	$ 564,738.59
23	438GA	Spirit Lake	1	Spirit Lake	IA	L	$ 2,044,571.69	$ 2,178,560.85
23	438GC	Sioux City	1	Sioux City	IA	L	$ 1,974,788.39	$ 1,905,574.66
23	438GD	Aberdeen (Brown County)	1	Aberdeen	SD	L	$ 1,838,170.43	$ 1,586,080.42
23	438GF	Watertown	1	Watertown	SD	V	N/A	$ 63,350.38
23	568GA	Rapid City SD	1	Rapid City	SD	L	$ 5,669,476.10	$ 5,617,300.27
23	568GB	Pierre	2	Pierre	SD	C	$ 1,282,928.54	$ 1,032,440.24
23	568HA	Newcastle	1	Newcastle	WY	L	$ 110,144.20	$ 58,771.49
23	568HB	Gordon	1	Gordon	NE	L	$ 140,173.58	$ 97,999.80
23	568HC	Alliance	1	Alliance	NE	L	$ 209,793.05	$ 183,235.58
23	568HE	Kyle	1	Kyle	SD	L	$ 74.04	$ 231.42
23	568HF	Pine Ridge	1	Pine Ridge	SD	V	$ 173,797.57	$ 120,162.55
23	568HH	Scottsbluff	1	Scottsbluff	NE	L	$ 1,023,058.07	$ 851,413.81
23	568HJ	Mission	1	Mission	SD	C	$ 204,290.46	$ 177,725.29
23	568HK	McLaughlin	1	McLaughlin	SD	L	$ 480,356.14	$ 505,860.48
23	568HM	Eagle Butte SD	3	Eagle Butte	SD	C	$ 451,978.10	$ 269,141.64
23	568HN	Lame Deer	1	Lame Deer	MT	L		
23	568HP	Winner	1	Winner	SD	C	$ 682,834.00	$ 495,180.61
23	618BY	Twin Ports	1	Superior	WI	L	$ 8,453,188.48	$ 6,642,518.54
23	618GA	South Central	3	St. James	MN	C	$ 1,545,077.99	$ 1,186,728.03
23	618GB	Hibbing	1	Hibbing	MN	C	$ 3,223,241.49	$ 2,032,853.42
23	618GD	Maplewood (St. Paul)	1	Maplewood	MN	L	$ 2,225,255.61	$ 2,259,020.69
23	618GE	Chippewa Valley	1	Chippewa Falls	WI	L	$ 2,534,352.92	$ 2,902,164.77
23	618GG	Rochester	1	Rochester	MN	L	$ 2,339,773.84	$ 2,355,652.99
23	618GH	Hayward	1	Rice Lake	WI	L	$ 1,170,824.33	$ 1,543,938.99
23	636A4	Grand Island	1	Grand Island	NE	V	$ 29,074,668.12	$ 26,239,939.30
23	636A5	Lincoln	1	Lincoln	NE	V	$ 36,632,042.69	$ 33,179,422.86
23	636GA	Norfolk NE	1	Norfolk	NE	L	$ 414,801.31	$ 938,434.72
23	636GB	North Platte	1	North Platte	NE	L	$ 1,491,769.84	$ 1,747,573.25
23	636GC	Mason City	1	Mason City	IA	L	$ 2,791,964.60	$ 2,623,475.43

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23	636GF	Bettendorf	1	Bettendorf	IA	L	$ 4,642,504.13	$ 4,295,755.47
23	636GG	Quincy	1	Quincy	IL	L	$ 1,340,920.94	$ 1,366,298.78
23	636GH	Waterloo	1	Waterloo	IA	L	$ 2,309,993.49	$ 2,137,476.43
23	636GI	Galesburg	1	Galesburg	IL	L	$ 1,860,928.17	$ 2,082,819.40
23	636GJ	Dubuque	1	Dubuque	IA	L	$ 2,129,841.28	$ 2,036,728.02
23	636GK	Fort Dodge	2	Fort Dodge	IA	C	$ 1,820,861.91	$ 1,581,762.69
23	636GL	Bellevue	1	Bellevue	NE	L	N/A	$ 342,613.58
23	636GN	Cedar Rapids	1	Cedar Rapids	IA	L	N/A	$ 20,745.00
23	636GP	Shenandoah	1	Shenandoah	IA	L	N/A	$ 465,108.18
23	636GQ	Holdrege	1	Holdrege	NE	L	$ 806,208.20	$ 857,200.08
23	656GA	Brainerd	1	Brainerd	MN	L	$ 3,128,677.52	$ 3,736,930.87
23	656GB	Montevideo	1	Montevideo	MN	L	$ 2,024,434.58	$ 1,808,895.93
23	656GC	Alexandria	1	Alexandria	MN	L	N/A	N/A
			783					

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Data Source: VAST DSS

Chairman AKAKA. Thank you, Senator Tester.

Senator Begich.

Senator BEGICH. Thank you very much, Mr. Chairman.

I just have some follow-up. And like Mr. Tester, I have to preside at 11 o'clock, so I will not be able to stay for a sizable amount of the second panel.

Mr. Mayes, I hate to put you back on the spot here but you made a good point. I want to follow up on it in regard to what sounded like you did an internal audit. When was that done?

Mr. MAYES. We did an internal audit. It was for the period June 2005 to May 2006. We have subsequently put in a regular audit process and we are auditing both of our contract exam providers twice a year at this point which we will continue in the future. These are some of the lessons we are learning.

Senator BEGICH. The process of repaying the billing or the inappropriate billing or however you want to categorize it, do you extend that contract every single year then?

Explain the contract procedure. Did you make modifications to the contract with the vendors in order to have a process to ensure—I understand your internal audit—that they have a certain responsibility or change in their procedures or a change in the way they operate; did you change anything in the contract?

Mr. MAYES. We have modified the contract to, I guess, refine the billing procedures is maybe the best way to say it, to make sure there is no ambiguity in what charges can be made for what services. We have done that. We are in the process of recompeting both contracts, so we are further refining that.

The contracts with the auditors are obviously separate and apart from the contracts for the vendors. So, what we wanted to do was not rely on just our internal quality controls—or for that matter the vendor's internal quality controls—but bring in a disinterested third party to take a look and protect our investment.

Senator BEGICH. Within the contracts that are about to go out, will you have some procedure or some process that clearly stipu-

lates, you know, if they have a certain error rate or percent of their amount allocated that goes in the wrong direction, meaning as you go through a process in theory if you are auditing and you are looking at the numbers, the problems should go down.

Otherwise you are just burning up money to verify what you probably can already identify. Is that part of the new contracting procedure? I do not know who can answer that.

Mr. MAYES. It is a very good point. We have an integrated product team that involves people from acquisitions and the program, and that is one of the issues that we are in the process of discussing.

Senator BEGICH. Let me put it another way. Should it be and will it be?

Mr. MAYES. Yes, I think that vendors should be accountable.

Senator BEGICH. Good. The customer satisfaction, again I know Senator Tester put you on the spot. I know customer satisfaction. I know when I was the chair of the Alaska Student Loan Corporation for 7 years, we did an analysis every quarter of our customers in determining the satisfaction of the quality of work, processing, and all the stuff that goes with it.

It also drove everything from how long they held on the phone waiting for service, how long it took them to get an appointment for loan processing—everything we did then helped us develop a better product and a better service.

Do you have that kind of robust customer service analysis? I know that is all you are in, the business of customer service, basically. I mean you are a service agency.

Mr. MAYES. Yes, Senator, that is exactly right. I can tell you what we look at in terms of customer satisfaction. In the contract 90 percent of the appointments—the veterans should not wait more than half an hour to get into the appointment. That is a component of our customer satisfaction.

Senator BEGICH. That is a benchmark, a measurement tool.

Mr. MAYES. Also there are actually five statements on that card that I referenced earlier in my response: the performance of administrative staff—the question is are you very satisfied, somewhat satisfied with that; reasonableness of appointment time and place; cleanliness of examiner's office; concern and attention demonstrated by the examiner; and then overall satisfaction with the services provided.

Senator BEGICH. Let me end with you there and say I would love to see annual numbers for the last few years, a trend line of what that looks like in some of those categories.

Mr. MAYES. It is very high.

Mr. BEGICH. That is great. If you can share with me that.

Mr. MAYES. We can do that, yes, sir.

[The additional information requested during the hearing follows:]

Results of Medical Disability Examination Project Customer Survey Cards: Percent of Veterans Very Satisfied or Somewhat Satisfied			
	2007	2008	2009
Performance of Administrative Staff	94.1%	94.6%	93.6%
Reasonableness of Appointment Time and Place	91.9%	92.6%	92.0%
Cleanliness of Examiner's Office	96.4%	96.6%	96.4%
Concern and Attention Demonstrated by Examiner	92.8%	93.2%	92.8%
Overall Satisfaction with Services Provided	93.3%	93.8%	93.6%

Senator BEGICH. The last thing. I will just end on this and that is the whole issue of credentialing folks who do service for the VA, and this could be just a very simple yes or no or you can get back to me.

If someone is already doing services for like Indian Health Services, are they automatically credentialed in the VA for the services provided to VA?

If they are providing the exact same service to the Indian Health Services, can they just go right over or do you create a whole new process? If you do not want to answer to the detail now——

Mr. WILLIAMS. Senator, I will take that for the record.

Mr. BEGICH. That would be great. Just of those services because that is the general question. I will leave it at that.

Thank you very much, Mr. Chairman.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MARK BEGICH TO JOSEPH A. WILLIAMS, JR., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. If someone is doing services for Indian Health Services, are they automatically credentialed in the VA for the services provided to VA? If they are providing the exact same service to the Indian Health Services, can they just go right over or do we create a whole new process?

Response. VA requires all practitioners delivering care in VA medical facilities to be credentialed and privileged by VA in accordance with VA policy prior to delivering care in the facility. This includes not only VA employees, but also all contract providers working on site. VA does not accept credentialing completed by another agency. In those instances where VA contracts for care with a specific provider outside of the VA facility, VA similarly requires that the specific provider be credentialed and privileged by the VA medical facility contracting for the provider to deliver care.

There are instances where VA plays the role of payer for care outside of VA through contractual agreements that do not list a specified provider. VA facility directors must ensure that there are oversight mechanisms in place to demonstrate consistent and effective care in accordance with the Joint Commission standards for accreditation, but there is not a requirement for VA credentialing and privileging, since the agency is not directing the care.

We note that, for the specific situation of providers shared between VA and the Department of Defense (DOD), there is currently a workgroup charged by the VA/DOD Executive Committee that is developing a Memorandum of Understanding (MOU) for the exchange of credentialing information between the two departments. The MOU will establish the guidelines for the sharing of credentialing data collected by one department to be used in the privileging of the practitioner by the other department, therefore facilitating the utilization of personnel across both departments.

Chairman AKAKA. Thank you very much, Senator Begich.

Mr. Williams, apparently VA recently published a directive barring the release of a contractor's inspections of VA nursing homes. I understand the VA said that the records contain protected information. Since taxpayers paid for those reports, should not that in-

formation be made public and how is the information in them protected if it has not disclosed the identity of either the patient or the provider?

Mr. WILLIAMS. Mr. Chairman, I am not intimately knowledgeable about that situation.

Chairman AKAKA. I am referring to the long-term care institute.

Mr. WILLIAMS. I will have to take that question for the record, sir, and get back to you.

Chairman AKAKA. Thank you.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. DANIEL K. AKAKA TO JOSEPH A. WILLIAMS, JR., ACTING DEPUTY UNDER SECRETARY FOR HEALTH, OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Since taxpayers paid for those reports, should not that information be made public and how is the information in them protected if it has not disclosed the identity of either the patient or the provider? I am referring to the long-term care institute.

Response. The reports that VA generates from its unannounced review program are for the purpose of managing quality of care and quality of life in VA Community Living Centers (CLC), formerly known as VA Nursing Homes. There is no directive barring the release of these documents. Rather, the documents are internal quality management documents and are therefore not subject to release under the Freedom of Information Act (FOIA) as stated in 38 U.S.C. § 5705.

38 U.S.C. § 5705 provides that records and documents created by VHA as part of a designated medical quality assurance program are confidential and privileged and may not be disclosed to any person or entity except when specifically authorized by statute. When requested under FOIA, the Act's Exception 3 provides that records should be withheld from disclosure when such records are specifically exempted from disclosure by another statute. Thus, the CLC reports must be withheld under FOIA Exemption 3, providing 38 U.S.C. § 5705 as the applicable statute.

The requirements for documents to be protected by 38 U.S.C. § 5705 include the following:

- First, the activity that generated the document must be conducted by or for VA to improve the quality of health care. The CLC reports are conducted as a means to perform unannounced program monitoring of quality of care provided in the CLCs.
- The final requirement for a document to be confidential under 38 U.S.C. § 5705 is that the document generated must have been previously designed in writing as a quality management document which can produce confidential documents. In VHA Directive 2008–077, Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents, the Under Secretary for Health specifically designates under paragraph 4(a)(1)(k) that documents resulting from service and program monitoring activities are confidential. The Directive is enclosed.

A verbal reminder of the FOIA restriction on release of quality management documents was given on a VA national conference call on Friday, September 25, 2009, to ensure VA's compliance with statutory requirements.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2008-077

November 7, 2008

QUALITY MANAGEMENT (QM) AND PATIENT SAFETY ACTIVITIES THAT CAN GENERATE CONFIDENTIAL DOCUMENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive lists and describes Quality Management (QM) activities which can generate confidential documents under Title 38 United States Code (U.S.C.) Section 5705, and its implementing regulations.

2. BACKGROUND

a. The confidentiality regulations state that the Under Secretary for Health, Veterans Integrated Service Network (VISN) Director, or facility Director must describe in advance, in writing, those quality assurance activities which generate confidential records under 38 U.S.C. 5705, and its implementing regulations. ***NOTE:*** *The terms "quality management," "quality improvement," and "quality assurance" are used interchangeably in this Directive; quality assurance is used as a synonym for quality management in the implementing regulations.*

b. The requirements for a QM document to be confidential are described in Title 38 Code of Federal Regulations (CFR) Sections 17.501 (a), (b), (c), and (g) of the confidentiality regulations. These requirements can be briefly summarized as follows: ***NOTE:*** *See 38 CFR 17.501 for a more precise and detailed description.*

(1) The activity that generated the information must have been conducted by or for the Department of Veterans Affairs (VA) to improve the quality of health care or the utilization of health care resources.

(2) The activity which generated the document must have been previously designated in writing as a QM activity which can produce confidential documents. The designation can be either by the Under Secretary for Health and applied to VHA facilities, or by a VISN Director to apply to all VHA facilities within that VISN, or by the facility Director to apply only to that facility.

(3) The document must meet one of the following conditions:

(a) It identifies, either implicitly or explicitly, individual practitioners, patients, or reviewers; or

(b) It contains discussions relating to the quality of VA medical care, or to the utilization of VA medical resources by health care evaluators during a review of quality assurance data.

(4) If the activity which generated the document was performed at a VA medical treatment facility, it must have been performed by staff of that facility or there must have been prior written designation of the role of individuals who were not staff at the facility in performing the review.

c. The list of core activities at all VHA medical facilities that can generate records protected by 38 U.S.C. 5705, and the implementing regulations, can be expanded under the following circumstances:

(1) VISN and facility Directors can supplement this list for facilities under their control by describing additional QM activities that can generate confidential documents in policy directives or QM Plans.

(2) The description of a QM activity in this Directive, or in a similar document signed by a VISN or facility Director, does not mean that all documents resulting from the activity are confidential. It is necessary that the other requirements (referred to in subparagraphs 2b and 2c) must be met. In particular, aggregate statistical information that does not implicitly or explicitly identify individual VA patients, VA employees, or individuals involved in the quality assurance process is not confidential. Similarly, summary documents which only identify study topics, the period of time covered by the study, criteria, norms, or major overall findings, and do not identify individual health care practitioners even by implication, are not confidential. Consequently, most documents resulting from some activities described in this Directive, such as process action teams, will not be confidential.

3. POLICY: It is VHA policy that only VHA documents which meet the requirements in 38 U.S.C. 5705 and its implementing regulations are confidential.

4. ACTION: The facility Director is responsible for:

a. Ensuring that the criteria referred to in subparagraphs 2b and 2c are met and that documents from the following quality assurance activities are confidential:

(1) **Monitoring and Evaluation Reviews.** Monitoring and evaluation reviews conducted by a facility include:

(a) Tort Claim Peer Review. A Tort Claim Peer Review is the review of the care provided in cases in which malpractice claims have been filed to identify, evaluate, and, where appropriate, correct circumstances having the potential to adversely affect the delivery of care. ***NOTE:*** *Reviews conducted entirely for other purposes, such as assisting the United States in consideration of tort claims or in defense of litigation under the Federal Tort Claims Act, are not included.*

(b) Morbidity and Mortality Reviews (including psychological autopsies). Morbidity and Mortality Reviews are discussions among clinicians of the care provided to individual patients who died or experienced complications. These discussions are scheduled and usually labeled as Morbidity and Mortality Conferences. Activities which involve preliminary reviews of care to provide material for consideration at Morbidity and Mortality Conferences are included. If non-VA practitioners from affiliated facilities attend Morbidity and Mortality conferences, there needs to be prior written designation of the role of these individuals if documents from these conferences are to be confidential. In addition, 38 U.S.C. Section 5701 bars access by non-VA

personnel to VA medical records or other documents identifying individual VA patients unless the identifying information has been deleted.

(c) Occurrence Screening. Occurrence Screening is the screening of cases against a list of criteria that are specified, in advance, in a policy document from the Under Secretary for Health, VISN Director, or facility Director. Cases that involve one or more of the occurrences are reviewed to identify possible problems in patient care. Cases meeting the criteria may be entered into an ongoing occurrence screening database to be reviewed and analyzed regularly to identify patterns that may be problematic. The Under Secretary for Health, VISN Director, or facility Director may delete criteria that they have previously authorized in a policy document.

(d) Drug Usage Evaluation. Drug Usage Evaluations are reviews to assess the safety, appropriateness, and effectiveness of drugs prescribed by physicians. The dose, route, and time schedule chosen are often reviewed, as well as the drug selected. Adverse drug event reports are included.

(e) Utilization Review. The Utilization Review identifies inappropriate, inefficient, or insufficient use of resources involved in clinical care, e.g., review of admission and continued hospitalization or review of diagnostic studies. A specific review may apply to all patients or to a specific group of patients defined by diagnosis, performance of a procedure, or other patient characteristics. Reviews of rejected applications for care are also included.

(f) Surgical and Other Procedure Usage Evaluation. The Surgical and Other Procedure Usage Evaluation is a review that assesses the appropriateness (whether the procedure was needed) and effectiveness of surgical and other procedures. It includes the review of cases in which there is a major discrepancy between preoperative and postoperative (including pathologic) diagnoses, and the review of specific invasive procedures, regardless of whether tissue was removed during the procedure.

(g) Medical Records Review. The Medical Records Review assesses the adequacy of medical record documentation by clinical staff with regard to completeness, timeliness, and clinical pertinence.

(h) Blood Usage Review. The Blood Usage Review is a review of all aspects of blood services to determine whether blood and blood products are appropriately ordered and stored, delivered, and provided in a safe, timely, and therapeutic manner. Evaluation of transfusion errors and reactions is included.

(i) Adverse Event and Close Call Reporting. Adverse Event and Close Call Reporting is the reporting, review, or analysis of incidents involving patients that cause harm or have the potential for causing harm. Employees becoming aware of such incidents report them to the medical center. ***NOTE:*** *Current examples of adverse events, which require review and reporting, are included in VHA Handbook 1051.01.* VA Form 10-2633, Report of Special Incident Involving a Beneficiary, or similar forms, and follow-up documents, unless developed during or as a result of a Board of Investigation, are confidential and privileged. Confidential

documents, such as Reports of Special Incidents, which lead to a Board of Investigation, retain their confidential status even though documents resulting from the Board of Investigation are not confidential.

(j) Infection Control Reviews. Infection Control Reviews are surveillance activities to identify and monitor the rate of nosocomial infections.

(k) Service and Program Monitoring including Multi-disciplinary Monitoring. Service and Program Monitoring are processes that involve indicators used by clinical services and programs to monitor the quality of specific aspects of the care they provide. The data from these indicators are periodically evaluated to identify opportunities for improvement. ***NOTE:*** *This monitoring and evaluation is multi-disciplinary when it involves several services reviewing the same care from their different perspectives.*

(l) Autopsy Review. An autopsy review is the comparison of pre-mortem diagnoses and diagnostic assessment procedures with post-mortem diagnoses and other autopsy findings to assess diagnostic accuracy. ***NOTE:*** *This review may be performed at a Morbidity and Mortality Conference or in other settings.*

(m) Process Action Teams. Process Action Teams are multi-disciplinary teams established to perform an in-depth study of the processes involved in providing clinical services. ***NOTE:*** *They are also known as quality improvement teams and are usually part of a facility's Total Quality Management Program.*

(2) **Focused Reviews.** Focused Reviews (including, but not limited to, Peer Review for Quality Management, National Surgical Quality Improvement Program (NSQIP), Continuous Improvement Cardiac Surgical Program (CICSP), Inpatient Evaluation Center (IPEC), or VHA Quality Improvement Program (VQuIP) focused reviews), and root cause analyses (RCAs), which address specific issues (usually of major consequences to patient care processes and outcomes) or specific incidents (usually involving a discrete episode of care), and which are designated by the responsible office at the outset of the review as protected by 38 U.S.C. 5705, and its implementing regulations, are considered confidential. Focused Reviews may be conducted by facilities, VISNs, or VHA Central Office. ***NOTE:*** *If it appears during a facility Focused Review that disciplinary action may be indicated, the medical center Director must determine if the Focused Review needs to be terminated and a Board of Investigation, whose findings can be the basis of disciplinary actions, initiated.* VHA Central Office or VISN Focused Reviews may involve comparison of facilities relative to each other on key indicators of quality of care. They are:

(a) Quality Improvement Checklist (QUIC). QUIC is a data system comparing VA medical facilities on key clinical indicators. QUIC is in operation at some, but not all, VA health care facilities.

(b) National Comparative Performance Analyses. National Comparative Performance Analyses are data analyses describing an individual facility's or VISN's performance on key

indicators of care relative to other facilities or VISNs. The analyses are based on national administrative databases, such as the Patient Treatment File (PTF), or data collected specifically for quality management purposes. Programs generating such analyses include the Performance Measurement Program and the NSQIP, CICSP, IPEC and VQuIP. ***NOTE:*** *Other national comparative performance analyses concern mortality on medical and psychiatric units, decubitus ulcers, and functional assessment of the patient. Reports generated under 38 U.S.C. 7311, involving system-wide surgical Morbidity and Mortality rates, are not included.*

(c) Trending and Analysis. VISN and VHA Central Office trending and analysis of facility quality management documents and data includes, but is not limited to: adverse drug reaction reports, reports of adverse events, and close calls.

(d) Root Cause Analysis (RCA). RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse clinical events or close calls.

1. An RCA investigates events and activities, gathers and manipulates data, and examines and reviews VHA care delivery activities in order to:

a. Identify the system elements or components that cause or contribute to the occurrence of an adverse clinical event or close call; and

b. Develop corrective actions and procedures for VHA to adopt both locally and nationally that will prevent the recurrence of similar events or close calls.

2. RCA usually involves:

a. The gathering and examination of patient-specific and provider-specific data.

b. Analysis and coordination between and among the facility, VISN, and national levels.

3. RCA may include reviews of several similar events, such as medication errors to derive common causal factors and solutions, and is commonly referred to as an aggregated review.

(e) Patient Safety Registry (PSR) and Patient Information System. The PSR and Patient Safety Information System is a central database that is used to report and monitor individual adverse events involving patients treated by VHA in VHA facilities.

1. Facility, VISN, and national VHA components investigate, examine, and analyze an event reported to the database in order to:

a. Identify basic or contributing causal factors that resulted in the adverse event; and

b. Develop protocols or procedures for VHA to adopt that will prevent a recurrence of the event.

2. The data usually involves:

a. The gathering and examination of patient-specific data.

b. Analysis and coordination of reported events at and between the facility, VISN, and national levels.

3. Analysis of data may involve a review of similar events from different facilities in order to derive common causal factors and solutions.

(3) **General Oversight Reviews.** VHA Central Office or VISN general oversight reviews to assess facility compliance with VA clinical program requirements, if the reviews are designated by the reviewing office at the outset of the review as protected by 38 U.S.C. 5705 and its implementing regulations.

(4) **External, Clinically-Oriented Reviews.** External, clinically-oriented reviews of care specifically designated in the contract or agreement as reviews protected by 38 U.S.C. 5705, and its implementing regulations (e.g., External Peer Review Program (EPRP).

(5) **Clinical Education Program Accreditation Reviews.** All education programs conducted in VA must be accredited by the nationally-recognized accreditation body, i.e., the Accreditation Council for Graduate Medical Education (ACGME), or those organizations listed in the Department of Education's Office of Postsecondary Education listing of "National Institutional and Specialized Accrediting Bodies" (see Web site: www.ed.gov/admins/finaid/accred/accreditation_pg8.html). These external review bodies have processes for initial and ongoing accreditation of their respective educational training program. Their review processes generate detailed reports addressing a wide range of program and institutional requirements. The reports may include information about specific VA training programs and resources (human and equipment) that would impact on the delivery of patient care; information about the training environment; and, critiques of the credentials and performance of individual faculty, physicians, and educators involved in the training program. The information is used to correct the identified shortcomings of VHA training programs and ensure that appropriate improvements are instituted.

b. Ensuring that patient representation programs cannot generate confidential documents. ***NOTE:*** *If a study or review following up a patient complaint needs to be confidential, it needs to be designated as a focused review.*

c. Indicating on confidential QM documents created after the publication of the revised regulations that the document is confidential under 38 U.S.C. 5705, and its implementing regulations. The specific QM activity under which the document is included must be designated. ***NOTE:*** *The activity names used are to be from this Directive or from a VISN or facility policy document that describes additional QM activities that can generate confidential documents.*

(1) The following statement is recommended, but not required for this purpose: "These documents or records, or information contained herein, which resulted from (name of specific QM program or activity), are confidential and privileged under the provisions of 38 U.S.C. 5705, and its implementing regulations. This material can not be disclosed to anyone without authorization as provided for by that law or its regulations. ***NOTE:*** *The statute provides for fines up to $20,000 for unauthorized disclosures."*

(2) The use of the disclosure, or a similar statement, is helpful in retrospectively identifying confidential documents. However, the statement by itself does not ensure confidentiality of a document. Documents which meet the requirements in 38 U.S.C. 5705, and its implementing regulations are confidential even if no such statement is present; similarly, the use of the disclosure statement does not protect documents which do not qualify under 38 U.S.C. 5705, and its implementing regulations.

d. Providing the level of protection reasonably necessary to ensure that access to and disclosure of documents, including electronic documents containing information protected by 38 U.S.C. 5705, occurs only as authorized by that statute and its implementing regulations. ***NOTE:*** *The manner in which this protection is to be provided is no longer specified by the confidentiality regulations.*

5. REFERENCES: Title 38 U.S.C. 5705.

6. FOLLOW-UP RESPONSIBILITIES: Chief, Office of Performance and Quality (10Q), is responsible for the contents of this Directive. Questions may be addressed to (202) 266-4533.

7. RESCISSION: VHA Directive 2004-051 is rescinded. This VHA Directive expires November 30, 2013.

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

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7

Chairman AKAKA. Under contract management, in light of some high-profile pass/failures like CoreFLS, what is being done to contract management in VA?

Mr. WILLIAMS. I will refer to Mr. Frye.

Chairman AKAKA. Mr. Frye.

Mr. FRYE. Thank you, Mr. Chairman.

First of all, I would like to distinguish between contract management and program management. Program managers are responsible for the cost schedule, performance, and quality of their programs.

Contracting officers support program managers by putting contracts in place and that is the tool that the program manager uses to get to his or her objectives.

So, oftentimes we intermix program management and contract management, and I just wanted to make that distinction if you will.

We have made a number of improvements in our overall VA contracting in the last year. For instance in the area of training, we have known we have had a training shortfall for sometime. We have stood up the VA Acquisition Academy in Frederick, Maryland. This is the only acquisition academy that I am aware of outside of the Department of Defense.

In this academy we train our contracting officers. Very soon we will begin training program and project managers. We train our contracting officer technical representatives; and we have also implemented an intern program where we are recruiting 30 interns per year.

This is a 3-year program. It is very robust. We have just recently brought on our second group of 30. So, at the end of 3 years, we will have approximately 100 interns in our program.

We are doing everything we can within our budget to raise up some of the younger folks coming straight out of school, and in some cases older people, as well, who decided to change career fields.

But the point is, we need to fill our pipeline with some very well trained professionals. It is very difficult, impossible as a matter fact, to just take someone off the street and put them to work in the contract arena. It takes time and money to get it done.

In addition, we have stood up three new procurement organizations in the VA. As you are well aware, we have had problems in the information technology arena.

We took advantage of the Army's base realignment and closure of Fort Monmouth, NJ. As you may know, they are moving to Aberdeen Proving Ground. We decided about a year ago to open up an office there in Eatontown, NJ. We are in the process of hiring over 200 contracting professionals as well as attorneys, engineers, and program managers; and this will greatly assist us in the execution of our information technology mission across the VA.

In addition, we have stood up an office that we termed the Center for Acquisition Innovation in Frederick, MD. The strategy there is that it is easier to have people drive against traffic. Instead of coming to Washington, DC, stay in Frederick, MD, or drive against the grain of traffic. We have recruited thus far over 30 contracting professionals there. They are mostly involved in the VA central office procurement requirement.

We have also stood an office up in Austin, TX. That office will be engaged primarily in support of the Office of Information Technology.

We have recently fielded a contract writing system across the VA that was fully operationally capable in July 2007. But just a few years ago we had no contract writing system. That has been a large undertaking for us.

We are installing business intelligence tools on top of that contract writing system so that we can measure things like procurement action lead time.

And we can actually go to our customers and say, look, we have your requirement and we predict that we will have your require-

ment on contract in a given period of time instead of leaving them guessing when we would get it done.

We are developing the acquisition corps, that is, c-o-r-p-s, much like the U.S. Army's. This is a process where we will identify critical program management and contract positions across the VA. We will then assign only certified acquisition corps members for those critical positions.

As also indicated earlier, we have developed processes like integrated product teams. The most difficult piece of the procurement business, the acquisition business, is developing the requirement.

We no longer do that by allowing someone to go in the corner and write a requirement by themselves. We now use integrated product teams so we have a collaborative effort in writing the requirements up front.

We are also moving to seek a lot of information from industry partners. We recently held a forum at the Ritz Carlton near the Pentagon, which we invited 120 vendors, and we have ongoing efforts with them to assist us. We had them identify areas where they think we are deficient. We are going to have them help us hopefully come to some means to improve our processes.

I would like to take a couple of minutes to say something about what we are doing on the program management side of the house.

You may or may not know that the Assistant Secretary for Information and Technology is reviewing all IT programs in the VA. They recently put, I believe, 27 programs "on pause" as they are calling it. They are taking a very close look at these programs. The programs may be canceled, but obviously they are under duress either in terms of performance or schedule, or perhaps cost.

The OIT is reviewing all of the IT programs. They are applying their program management accounting assistant or PMAS system to these programs. Again, some programs may be canceled or restructured if they are behind schedule or over budget.

Program managers across the VA will soon be trained in our VA Acquisition Academy. We are planning on training several thousand program managers next year. This will not be done alone at our academy. We will have industry partners help us do that.

It will be an attempt to bring up all program managers at a given level, and then we will go from there. There is further training to be done but we want to make sure that all of them have a common grounding in program management skills.

I think all of those things take a holistic approach to improving the big "A," Acquisition, not only for contracting or procurement, but program management and all of the other skill sets that we need to effectively manage our programs across the VA.

Chairman AKAKA. Thank you very much, Mr. Frye.

I want to thank you very much for your responses. Before I dismiss this panel, I would like you to take back to VA my concern about the situation in American Samoa and the Philippines.

I want to know that VA is doing everything possible to help in the wake of the recent natural disaster there. Many veterans in American Samoa and the Philippines have served this country honorably and all of those affected deserve any help we can give them. I thought I would mention it to you and to the VA through you.

So, I want to thank you very much again. This area of contracting, of course, is a huge concern to all of us and we need to look at the challenges that we are facing in contracting and begin to try to improve the system. No one knows better than you what needs to be done, but we certainly want be a part of that. However we can help, legislatively even, we would like to do that.

Again, I thank you very much first panel.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO HON. JOSEPH A. WILLIAMS, JR., ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VHA, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. VA has over 2000 active contracts. At the hearing, ACS testified that each of their 6 contracts was interpreted differently by local contracting officials. What will the restructuring of the acquisitions organization do to remedy this problem for ACS and all other VA contractors?

Response. It is important the Department of Veterans Affairs (VA) industry partners receive the same general guidance and interpretations from the Department's acquisition workforce. To begin achieving this the has Secretary directed that the Office of Acquisition, Logistics and Construction establish a plan that moves the Department's contracting operations to an integrated model with the potential to go to a centralized model based on a series of performance measures to be reviewed in 18–24 months. Organizing the VA Acquisition Enterprise in an integrated fashion and commodity-driven Centers of Excellence will enhance VA's ability to deploy uniform guidance to all contracting officers, regardless of geographic location. While organizational change will play a role in our relationships with suppliers the key driver is educating our contracting staffs on how they relate to our customers. To provide our contracting officers these critical skills the VA Acquisition Academy has an in-depth program that offers contracting officers across the Department the necessary courses to hone their skills in performing their jobs. As a condition of maintaining their buying warrants contracting officers must take 80 hours of continuing education courses every twenty four months to remain certified.

Question 2. Please provide a written description of how you are complying with OMB's directive to reduce agency reliance on contractors, including a detailed description of the implementation status of OMB's required pilot program.

Response. VA is complying with OMB's directive to reduce agency reliance on contractors by implementing OMB's required pilot program. VA identified the Office of IT Enterprise Strategy, Policy, Plans and Programs in the Office of Information & Technology to oversee its Multi-Sector Workforce pilot. VA assembled a pilot team with representation from the Office of Information Technology; Office of Human Resources and Administration; Office of Budget; Office of Policy and Planning; Office of Acquisition and Logistics; Veterans Health Administration; National Cemetery Administration; and Veterans Benefits Administration. The team has followed the "Framework for Managing the Multi-Sector Workforce" in OMB Memorandum M–09–26. The team has analyzed the strategic plans, contracts, FAIR Act Inventory classifications, cost models, workforce competencies and sources of talent. The team has identified the limitations on the number of authorized Federal positions and the cumbersome hiring process as obstacles to bringing work in-house. An action plan to address these obstacles to recruitment and hiring is currently under development.

Question 3. Cardinal Health, Inc. holds a contract with VA worth $136 million. What services are provided to VA under this contract, and in what facilities? Please include the location of the facilities (city, state).

Response. The Cardinal Health, Inc. (Cardinal) contract is a prime vendor contract for the distribution of medical and surgical products. Medical Surgical Prime Vendors (MSPVs) warehouse and distribute products for VA identified on various VA national, regional and local contracts, and agreements. MSPVs deliver products to VA facilities within 24–72 hours. This allows VA to obtain the medical and surgical products specified, from a single prime vendor for all facilities under the contract. This provides ease of ordering, reduces the number of purchase orders, reduces the number of shipments received, the number of invoices processed by medical centers, and helps reduce facility inventory levels.

The following VA facilities [Veterans Integrated Service Network (VISN)] and other Government Agencies are covered by the Cardinal contract:

VISN 3

- VA Medical Center
  130 W. Kingsbridge Road, Bronx, NY 10468
- VA Hudson Valley Healthcare System
  – Castle Point, NY 12511
  – 622 Albany Post Road, Montrose, NY 10548
- VA New Jersey Healthcare System
  – 385 Tremont Avenue, East Orange, NJ 07018
  – 151 Knollcroft Road, Lyons, NJ 07939
  – Outpatient Clinic, 970 Route 70, Brick, NJ 08724
- VA New York Harbor Healthcare System:
  – 800 Poly Place, Brooklyn, NY 11209
  – 423 E. 23rd Street, New York, NY 10010
  – 179th Street and Linden Boulevard, St. Albans, NY 11425
- VA Medical Center
  79 Middleville Road, Northport, NY 11768

VISN 4

- VA Medical Center
  2907 Pleasant Valley Boulevard, Altoona, PA 16602
- VA Medical Center
  325 New Castle Road, Butler, PA 16001
- VA Medical Center
  One Medical Center Drive, Clarksburg, WV 26301
- VA Medical Center
  1400 Black Horse Hill Road, Coatesville, PA 19320
- VA Medical Center
  135 E. 38 Street, Erie, PA 16504
- VA Medical Center
  1700 S. Lincoln Avenue, Lebanon, PA 17042
- VA Medical Center
  University & Woodland Avenue, Philadelphia, PA 19104
- VA Pittsburg Healthcare System
  – Progressive Care Center (Aspinwall Division)
    Delafield Road, Pittsburg, PA 15260
  – 7180 Highland Drive, Pittsburgh, PA 15206
  – University Drive, Pittsburgh, PA 15240
- VA Medical Center
  1111 E. End Boulevard, Wilkes-Barre, PA 18711
- VA Medical Center
  1601 Kirkwood Highway, Wilmington, DE 19805

VISN 5

- VA Maryland Healthcare System:
  – 10 N. Greene Street, Baltimore, MD 21201
  – Bldg. #11, Perry Point, MD 21902
- VA Medical Center
  510 Butler Avenue, Martinsburg, WV 25401
- VA Medical Center
  50 Irving Street, N.W., Washington, DC 20422

VISN 6

- VA Medical Center
  1100 Tunnel Road, Asheville, NC 28805
- VA Medical Center
  200 Veterans Avenue, Beckley, WV 25801
- VA Medical Center
  508 Fulton Street, Durham, NC 27705
- VA Medical Center
  2300 Ramsey Street, Fayetteville, NC 28301
- VA Medical Center
  100 Emancipation Drive, Hampton, VA 23667
- VA Medical Center
  1201 Broad Rock Road, Richmond, VA 23249
- VA Medical Center
  1970 Roanoke Blvd., Salem, VA 24153
- VA Outpatient Clinic
  190 Kimel Park Drive, Winston-Salem, NC 27103

- VA Medical Center
  1601 Brenner Avenue, Salisbury, NC 28144
- Charlotte Outpatient Clinic
  8601 University East Drive, Charlotte, NC 28213

VISN 7

- VA Medical Center
  1670 Clairmont Road, Decatur (Atlanta), GA 30033
- VA Medical Center
  Uptown Warehouse, 1 Freedom Way, Augusta, GA 30904
- VA Medical Center
  (Downtown), 800 Bailie Drive, Augusta, GA 30901
- VA Medical Center
  700 S. 19th Street, Birmingham, AL 35233
- VA Central Alabama Healthcare System
  – 215 Perry Hill Road, Montgomery, AL 36109
  – 2400 Hospital Road, Tuskegee, AL 36083
- VA Medical Center
  109 Bee Street, Charleston, SC 29401
  (Ship to: 1001 Trident Street, Trident Industrial Park, Hanahan, SC 29406)
- VA Medical Center
  6439 Garners Ferry Road, Columbia, SC 29209
- VA Medical Center
  1826 Veterans Boulevard, Dublin, GA 31021
- VA Medical Center
  3701 Loop Road E, Tuscaloosa, AL 35404

VISN 9

- VA Medical Center
  1540 Spring Valley, Huntington, WV 25704
- VA Medical Center
  1101 Veterans Drive, Lexington, KY 40502
- VA Medical Center
  2250 Leestown Road, Bldg. 12, Lexington, KY 40511
- VA Medical Center
  800 Zorn Avenue, Louisville, KY 40206
- VA Medical Center
  1030 Jefferson Avenue, Memphis, TN 38104
- VA Medical Center
  Sidney & Lamont Street, Mountain Home, TN 37684
- Tennessee Valley Healthcare System
  – 3400 Lebanon Pike, Murfreesboro, TN 37129
  – 1310 24th Avenue S., Nashville, TN 37212
- VA Outpatient Clinic
  9031 Cross Park Drive, Knoxville, TN 37923

VISN 10

- VA Medical Center
  10000 Brecksville Road, Brecksville, OH 44141
- VA Medical Center
  Bldg. 23 (Warehouse) & Bldg. 24 (SPD) 17273 State Rt. 104
  Chillicothe, OH 45601
- VA Medical Center
  3200 Vine Street, Cincinnati, OH 45220
- VA Medical Center
  10701 E. Boulevard, Cleveland, OH 44106
- VA Ambulatory Care Center
  420 N. James Road, Columbus, OH 43219
- VA Outpatient Clinic
  543 Taylor Avenue, Columbus, OH 43203
- VA Medical Center
  4100 W. 3rd Street (Buildings #126 & #330), Dayton, OH 45428

VISN 11

- VA Ann Arbor Healthcare System
  2215 Fuller Street, Ann Arbor, MI 48105
- VA Medical Center
  5500 Armstrong Road, Battle Creek, MI 49015
- VA Illiana Healthcare System

1900 E. Main Street, Danville, IL 61832
- VA Medical Center
  4646 John R. Detroit, MI 48201
- VA Medical Center
  1481 W. 10th Street, Indianapolis, IN 46202
- VA Northern Indiana Healthcare System
  2121 Lake Avenue, Fort Wayne, IN 46805
  1700 E. 38th Street, Marion, IN 46953
- VA Medical Center
  1500 Weiss St., Saginaw, MI 48602

VISN 12

- Chicago Healthcare System
  2030 W. Taylor Street, Chicago, IL 60012
- VA Medical Center
  5th & Roosevelt Road., (Supply Warehouse and Bldg. #4), Hines, IL 60141
- VA Medical Center
  325 East "H" Street, Iron Mountain, MI 49801
- VA Medical Center
  2500 Overlook Terrace, Madison, WI 53705
- VA Medical Center
  – 5000 W. National Avenue (Bldg. 111), Milwaukee, WI 53295
  – Appleton CBOC, 10 Tri-Park Way, Appleton, WI 54914
- VA Medical Center
  – 3001 Green Bay Road, (Bldg. 138) North Chicago, IL 60064
  – Green Bay CBOC, 141 Siegler Street, Green Bay, WI 54303
- VA Medical Center
  – 500 E. Veterans Street (Bldg. #452), Tomah, WI 54660
  – Emergency Pharmacy Service, Bldg. 37, Hines, IL 60141

VISN 15

- VA Medical Center
  800 Hospital Dr, Columbia, MO 65201
- VA Eastern Kansas Healthcare System
  – 4101 S. 4th Street Trafficway (Leavenworth Campus)
    Leavenworth, KS 66048
  – 2200 Gage Boulevard (Topeka Campus), Topeka, KS 66622
- VA Medical Center
  4801 Linwood Boulevard, Kansas City, MO 64128
- VA Medical Center
  2401 West Main Street, Marion, IL 62959
- VA Medical Center
  1500 N. Westwood Blvd., Poplar Bluff, MO 64128
- VA Medical Center
  915 N. Grand Blvd., St. Louis, MO 63106
- VA Medical Center
  5500 E. Kellogg, Wichita, KS 67218

VISN 16

- VA Medical Center
  Alexandria, LA 713306
- VA Medical Center
  1100 N. College Avenue, Fayetteville, AR 72703
- VA Gulf Coast Healthcare System
  400 Veterans Avenue, Biloxi, MS 39531
- VA Medical Center
  2002 Holcombe Boulevard, Houston, TX 77030
- VA Medical Center
  1500 E. Woodrow Wilson Drive, Jackson, MS 39216
- Central Arkansas Veterans Healthcare System
  – 2200 Forts Roots Drive (NLR), Building #182, N. Little Rock, AR 72114
  – 4300 W. 7th Street, (LR), Little Rock, AR 72205
- VA Medical Center
  1011 Honor Heights Drive, Muskogee, OK 74401
- VA Medical Center
  1601 Perdido Street, New Orleans, LA 70112
- VA Medical Center
  921 NE 13th Street, Oklahoma City, OK 73104
- VA Medical Center

510 E. Stoner Avenue, Shreveport, LA 71101

VISN 17

- VA North Texas Healthcare System
  – 1201 E. 9th St., Bonham, TX 75418
  – 4500 S. Lancaster Road, (Bldg. #44), Dallas, TX 75216
  – 4500 S. Lancaster Road, (Bldg 2j Dock), Dallas, TX 75216
- VA Central Texas Veterans Healthcare System
  1901 Veterans Memorial Drive, Temple, TX 76504
- VA South Texas Veterans Healthcare System
  7400 Merton Minter Blvd, San Antonio, TX 78229
- VA Outpatient Clinic
  2901 Montopolis Drive, Austin, TX 78741
- VA Outpatient Clinic
  300 West Rosedale Street, Fort Worth, TX 76104
- VA Supply Warehouse
  3600 Memorial Boulevard, Kerrville, TX 78028
- Brownwood CBOC
  2600 Memorial Park Drive, Brownwood, TX 76801
- Cedar Park CBOC
  701 E. Whitestone Boulevard, Cedar Park, TX 78613
- College Station CBOC
  1605 Rock Prairie Road, College Station, TX 77845
- Palestine Community CBOC
  3215 W. Oak Street, Palestine, TX 75801

VISN 18

- VA Amarillo Healthcare System
  6010 Amarillo Boulevard, W. Amarillo, TX 79106
- VA El Paso Healthcare System
  300 N. Piedras Street, El Paso, TX 79930
- VA New Mexico Healthcare System
  1501 San Pedro Drive SE, Albuquerque, NM 87108
- VA N. Arizona Healthcare System
  500 N. Hwy 89, Prescott, AZ 86313
- VA Medical Center
  650 E. Indian School Road, Phoenix, AZ 85012
- VA S. Arizona Healthcare System
  3601 S. 6th Avenue, Tucson, AZ 85723
- VA W. Texas Healthcare System
  300 Veterans Boulevard, Big Spring, TX 79720
- VA Outpatient Clinic
  6104 Avenue, Q South Drive, Lubbock, TX 79412

VISN 19

- VA Medical Center
  2360 E. Pershing Boulevard, Cheyenne, WY 82001
- Eastern Colorado Healthcare System
  1055 Clermont Street, Denver, CO 80220
- VA Montana Healthcare System
  1892 Williams Street, Fort Harrison, MT 59636
- VA Medical Center
  2121 N. Avenue, Grand Junction, CO 81501
- VA Salt Lake City Healthcare System
  500 Foothill Drive, Salt Lake City, UT 84148
- VA Medical Center
  1898 Fort Road, (Bldgs. #35 & #71), Sheridan, WY 82801
- VA Outpatient Clinic
  1300 Fortino Boulevard, Suite B, Pueblo, CO 81008
- Miles City Clinic and Nursing Home
  210 S. Winchester, Miles City, MT 59310

VISN 20

- VA Medical Center
  500 W. Fort St., Boise, ID 83702
- VA Medical Center
  3710 SW US Veterans Hospital Road, Portland, OR 97239
- VA Medical Center
  4th Plain & St. Johns Road, Vancouver, WA 98661

- VA Roseburg Healthcare System
  913 NW Garden Valley Boulevard, Roseburg, OR 97470
- VA Puget Sound Healthcare System
  1660 S. Columbian Way, Seattle, WA 98108
- VA Medical Center
  4815 N. Assembly Street, Spokane, WA 99205
- VA Medical Center
  77 Wainwright Drive, Walla, Walla, WA 99362
- Southern Oregon Rehabilitation Center & Clinics
  8495 Crater Lake, White City, OR 97503
- Oregon Veterans Home
  700 Veterans Drive, The Dalles, OR 97058

VISN 22

- VA Loma Linda Healthcare System
  11201 Benton Street, Loma Linda, CA 92357
- VA Long Beach Healthcare System
  5901 E. 7th Street, Long Beach, CA 90822
- VA Greater L.A. Healthcare System
  11301 Willshire Boulevard, Los Angeles, CA 90073
- VA So. Nevada Healthcare System
  P.O. Box 360001, N. Las Vegas, NV 89036
- VA San Diego Healthcare System
  3350 La Jolla Village Drive, San Diego, CA 92161
- VA SepuAE1lveda Ambulatory Care Center
  Bldg. 200, 16111 Plumber, N. Hills, CA 90073

Hawaii

- VA Pacific Island Healthcare System
  459 Patterson Road, Honolulu, HI 96819
- VA CBOC—Hilo
  1285 Waianuenue Avenue, Suite 211, Hilo, HI 96720
- VA PTSD Residential Rehabilitation Program—Hilo
  891 Ululani Street, Hilo, HI 96720
- VA CBOC—Kona
  75–5995 Kuakini Highway, Suite 413, Kailua-Kona, HI 96740
- VA CBOC—Kauai
  3367 Kuhio Highway, Suite 200, Lihue, HI 96766
- VA CBOC—Maui
  203 Ho'ohana Street, Suite 300, Kahului, HI 96732
- VA CBOC—Guam
  US Naval Hospital, Bldg. 1, E–200, Box 7608, Agana Heights, Guam 96919

Alaska

- Alaska VA Healthcare System
  2925 Debarr Road, Anchorage, AK 99508

OTHER GOVERNMENT AGENCY (OGA)

Indian Health Services

- National Supply Service Center
  501 NE 122nd Street, Suite F, Oklahoma City, OK 73114–8138
- WW Hasting Hospital
  100 S. Bliss, Tahlequah, OK 74464
- Claremore Indian Hospital
  101 S. Moore Street, Claremore, OK 74017
- Choctaw Nation Health Care Center
  1 Choctaw Way, Talihina, OK 74571
- Lawton IHS Hospital
  1515 Lawrie Tatum Road, North of Lawton, Lawton, OK 73507
- Choctaw Nation Health Clinic
  902 East Lincoln Road, Idabel, OK 74745
- Choctaw Nation Health Center
  P.O. Box 340, 410 North M. Hugo, OK 74743
- Rubin White Health Clinic
  109 Kerr Avenue, Poteau, OK 74953
- Choctaw Nation Clinic
  1300 Martin Luther King Drive, Broken Bow, OK 74728
- Choctaw Nation Health Center

1127 S. George Nigh Expressway, McAlester, OK 74501
- Choctaw Health Center
  210 Hospital Circle, Philadelphia, MS 39350–6781
- Wewoka Clinic
  P.O. Box 1475, US State Highway 56 & 270 Junction, Wewoka, OK 74884–1475
- Clinton IHS Health Center
  Rt. 1, Box 3060, Clinton, OK 73601–9303
- El Reno Health Center
  1631-A East Highway 66, El Reno, OK 73036–5769
- Watonga Health Center
  Rt. 1, Box 34-A, 1 Mile S on Highway 281, Watonga, Oklahoma 73772
- Cherokee Indian Hospital
  HC–1 Box 9700, Kickapoo Tribal Health Reservation, Rosita Valley Road, Cherokee, NC 28771

Federal Bureau of Prisons
- Federal Correctional Complex
  5880 State Highway 67 South, Florence, CO 81226–7500
- Federal Correctional Complex
  Federal Medical Center, Old North Carolina Highway 75, Butner, NC 27509

Question 4. In a staff briefing, VA stated that their industrial fee was lower than any other Federal agencies. Do you intend to adjust this fee in light of the increased costs associated with restructuring the Acquisitions Department? What do you anticipate the cost of the restructuring to be?

Response. At this time, VA does not plan to increase the industrial funding fee (currently at 0.5 percent). The Department plans to charge fees for contractual services provided by the new organization and to use the flexibility of the Supply Fund to manage restructuring costs. The Department will have better projections of the cost of restructuring as we continue to define the new organization. The implementation plan for this restructuring is anticipated to be complete by the end of the third quarter of FY 2010.

Question 5. Mr. Brown testified that program officers are responsible for oversight of the programs, while contracting officers are only responsible for the contracts. How do contracting officers communicate with program managers to ensure that the terms of the contract comply with the quality standards of the program?

Response. (Please note this question references testimony given by Mr. Brown. However, this testimony was actually provided by Mr. Frederick Downs, Jr., Chief Prosthetics and Clinical Logistics Officer, Veterans Health Administration.) Contracting officers (CO) are actively engaged with program managers in the acquisition planning phase of the procurement process to ensure that appropriate contract administration procedures are established including: (a) a list of terms and conditions related to administration functions; b) contract milestones; (c) Quality Assurance Guidelines; (d) Inspection and Acceptance procedures; and (e) modification process. Contracting Officer's Technical Representatives (COTRs) are subject matter experts in given program offices and communicate and serve as a bridge between the Contracting Officers and Program Offices. The CO delegates limited oversight functions to the COTR to ensure the contractors' performance and delivery schedule are in accordance with the terms and conditions of the contract. Any issues related to the terms and performance of the contract is reported to the CO by the COTR. The CO then communicates with the program office based on the method of communication established at the pre-award meeting.

Question 6. VA employs individuals who purchase goods or services for the agency who are not GS–1102 contract specialists. In what acquisitions and purchasing roles are these individuals currently utilized?

Response. Warranted non–1102 purchasing agents are used for small purchasing activities of supplies, services, and prosthetics equipment for open market procurements below the simplified acquisition threshold (SAT) ($100,000), and delivery and task orders up to the maximum order limit against Federal supply schedule contracts.

Question 7. VA informed staff in a briefing that VA intends to certify purchasing agents who are not GS–1102 contract specialists. What are the advantages to certification? Has VA engaged AFGE or other employee organizations about this potential change?

Response. Certifying non–1102 purchasing agents offers several advantages and benefits to VA including:

(a) Standardizing core training, education and experience requirements to assure uniformity of performance and acquisition standards;

(b) Developing a trained, professional corps of acquisition professionals skilled and dedicated to deliver the best value in supplies and services to the agency and the Government;

(c) Certifying supports the implementation of the Office of Federal Procurement Policy Letter 05–01, Developing and Managing the Acquisition Workforce to better train and establish contracting and procurement personnel; and

(d) Standardizing small purchasing procedures and processes across VA constituent agencies and offices.

VA will reach out to AFGE and relevant employee groups once certification standards and practices are established to preserve collective bargaining agreements and to enhance employee participation in improving agency acquisition practices.

Question 8. If contractors for dialysis services change, are veterans already receiving dialysis offered the option of continuing at the same facility, or are they required to change to a new facility?

Response. When contracts are established, VHA will make an assessment on the appropriate timeframe to move patients to a new contract. These decisions are based on clinical needs of the Veterans. If there are no clinical concerns, VA will transition Veterans to new contract providers, which may entail referring patients to a different facility. This change will also consider an appropriate transition time to assure quality of care is not impacted. In the case of this specific dialysis contract, assessments are made concerning the most clinically appropriate setting, Veterans are notified in advance of VA's decision and when appropriate, provided clinical appeal rights and due process.

Question 9. In the *Independent Budget* for FY10, the following statement appears on p. 145: "VA does not track this care [purchased care], its related costs, outcomes, or customer satisfaction levels." Is this true for care purchased by VA on a fee-for-service basis? If so, does VA intend to change the current process?

Response. VHA does track and monitor purchased care, including those services purchased under contracts or in the traditional fee-for-service program. Monitors of expenditures occur on a routine basis, both at the VA Medical Center level and the enterprise level. Within contracts, VHA track results based on the clinical services purchased. For example, when diagnostic services are purchased under a contract, VHA includes this documentation in its electronic medical record. Contractual metrics are tied to each contract. Within Project HERO, metrics are received on a monthly and quarterly basis. Monthly metrics include items such as patient wait times, appointments received within 30 days of request, and return of clinical information (30 day standard).

At present, customer satisfaction is routinely assessed as a component of the Project HERO program. VHA is developing an initiative to expand this customer satisfaction assessment to all purchased care services. This initiative is currently in the initial planning phases.

Question 10. Do all facilities process claims from private providers for fee services in the same way? If not, how do processes vary, and what is being done to create an IT infrastructure that would permit standardization?

Response. Although the organizational structure for processing claims varies among facilities, VA uses its standardized software product, known as "VistA Fee" to process Fee Basis claims for payment. The processing of claims for services purchased by contract or sharing agreement may be accomplished using means other than VistA Fee, such as online certification.

VistA Fee was developed in the mid-1990s. Its automated processing capabilities need modernization to keep abreast of coding, billing and payment changes in the industry, such as automated code-editing practices, as well as updates to its processing capabilities to accommodate legislative changes.

A full analysis of the existing and future needs of a claims processing replacement system for all VA-purchased care is underway. In the interim, VA is installing a commercial off-the-shelf (COTS) product on top of VistA Fee, the Fee Basis Claims (FBCS) that improves inventory management through use of scanning capabilities, claims editing, and automated processing capabilities in the payment of non-VA health care claims.

Question 11. Exactly how many current contracts for health services does VA have, and how does VA track performance under those contracts? This should include two categories: all contracts paid for out of the medical services appropriation, and a second category for those contracts paid for from other sources.

Response. The VA Electronic Contract Management System (eCMS) currently contains 4,524 active Health Care Resources contracts. Contracting Officers (COs) assign a designation of health care when entering contract records into eCMS based on the type of service being procured, not by funding/appropriation. VA eCMS,

owned by the Office of Acquisition and Logistics (OA&L), is the official system of record for VA contract actions. The system currently does not have the functionality to allow VA to pull databased on the funding/appropriation codes.

COs track contract performance by obtaining contract performance information from their designated Contracting Officer Technical Representative (COTRs). Through the issuance of the COTR delegation of authority, COs delegate routine contract administration functions, which includes monitoring contract performance to their COTRs. The role of the COTR is to monitor the contractors' performance to ensure performance conforms to the contract's terms and conditions, and to elevate any concerns, issues, or suggested actions to the COs as necessary. COs also advise contractors of identified performance issues and request action plans to resolve issues. COs utilize all remedies available under VA and Federal Acquisition Regulations to deal with contractors that fail to perform. Performance issues are documented accordingly in the contract file.

Question 12. VA has a goal of completing contract renewals in 140 calendar days or 240 calendar days in the event a pre-award review is necessary. Vendors have reported to the Committee that GSA completes this process in 60 days or less. Why does it take VA longer to complete contract renewals?

Response. VA's Procurement Reform Taskforce (PRTF) established a metric of 180 calendar days to complete a Federal supply schedule (FSS) offer negotiation, which is the standard used to measure progress under the program. Procedural Guideline #22, an internal VA document establishing contract audit procedures, also provides for an additional 90 calendar days for the Office of Inspector General to complete any required pre-award reviews. General Services Administration (GSA) confirmed with VA that its normal processing times are in line with what VA experiences. There are two major differences between VA and GSA program management. These are:

(a) GSA implemented a Quick Program allowing for some offers to be streamlined and completed within 30 work days. These offers must meet specific criteria to include having a structured commercial pricing scheme and a straight forward, streamlined proposal. Also, these vendors must complete pre-offer training assignments requiring completion of various compliance checks prior to even submitting offers for consideration. VA is currently moving toward implementing a similar program, limited to select offers that can be identified as straight forward and meeting pre-offer training requirements. VA is currently formulating the requirements and processes needed for this type of program. The program draft is expected to be completed in June 2010. Once approved, all FSS solicitations will be updated to include the provisions for the Quick Program including the requirement for pre-offer training. We expect the program will be in place by December 2010.

(b) For offers that do not meet the criteria for the Quick Program, mainly those offers from current or past FSS contractors who had annual Federal sales of $3 million or more, a pre-award review must be performed. VA, with GSA's approval, continues to maintain the requirement for pre-award reviews. This adds time to the process, increasing overall workload and overall processing times. VA not only establishes and awards the FSSs for health care related products and services; it also has a vested interest as a buyer. Because the health care industry has a complex matrix of customers and related terms and conditions, VA performs these pre-award reviews to ensure a fair and reasonable price is attained. It should be noted that the GSA timeline for processing offers which do not fall under the Quick Program, is comparable to VA's timeline.

Question 13. VA's Office of Inspector General Report 05–01670–04 (October 15, 2007), as well as an earlier report from 2001, recommends that medical device manufacturers be required to contract directly with the Federal Government. What is VA's position on this recommendation?

Response. VA believes mandating that all medical device manufacturers deal directly with VA would prevent many small businesses from doing business with VA and/or other Federal agencies. Many manufacturers do not have a distributor network to sell and fill orders. Additionally, those manufacturers with an established distributor network may be forced to renegotiate contracts with distributors as a VA mandate may put the firms in "breach of contract" with those distributors.

Question 14. In VISN 23, the Black Hills VA Health Care System was budgeted for $17 million in FY10 for non-VA care, but spent $25 million in FY09. How much of the spending in FY09 is for care furnished under Project HERO, and how is it that this system would budget for less non-VA care in FY10 than was incurred in FY09?

Response. In FY09, Black Hills Health Care System (BHHCS) spent $185,254 on care purchased through the Project HERO contracts with Humana Veterans

Healthcare Services and Delta Dental Federal Services. Overall spending for care purchased in the community by Black Hills in FY09 was just over $25M. The budget for FY2010 in Black Hills for purchased care is $24M. Throughout VISN 23, VAMCs are working to maximize the use of "within VA network" resources where possible and to assure efficient use of non-VA Healthcare dollars when referrals into the community are necessary. Black Hills is expected to gain efficiencies through effective screening to assure referrals are in line with evidence-based care and use of Project HERO where available and when there is a cost-benefit. Therefore, the budget for FY10 is less than the FY09 actual spending.

Question 15. How many complaints has VA received from veterans concerning the timeliness or quality of compensation and pension examinations provided by VHA compared to those provided under contract? Describe the actions taken to address such complaints.

Response. VA sends customer surveys to Veterans for each contract medical exam they attend. The majority of complaints or comments are received through this medium, although Veterans occasionally contact their local Regional Office (RO) with a concern. The chart on the next page summarizes surveys received regarding timeliness and quality.

Table 1.—Contract Exams Customer Service: Timeliness and Quality
January 26, 2009–September 25, 2009

Contractor	Surveys Returned	Veterans waiting > 1 hour	Veterans "very dissatisfied" with examiner	Veterans "somewhat dissatisfied" with examiner
MES	4,456	91	81	52
QTC	34,199	754	617	661

To address complaints, Compensation & Pension (C&P) contacts the contractors and asks them to contact the Veteran. The contractor then reports the status to VBA. If an acceptable outcome is not achieved, the contractor is either asked to not utilize the examiner again or to put the examiner on notice.

VA has no record of receiving Veterans' complaints about the timeliness or quality of compensation and pension examinations performed by VHA vis-a-vis those performed by contract providers. However, the Compensation and Pension Examination Program (CPEP) is in the process of developing a VHA C&P customer satisfaction survey. The survey questions have been field-tested and are awaiting OMB approval.

Question 16. Describe the procedures for identifying VHA and contracted C&P examiners whose examinations or reports do not comply with VA policy, and the actions taken when non-compliance is identified.

Response. VBA does not have access to information from VHA for a comparison. Each medical disability examination administered by a contractor for C&P is reviewed for quality based on Automated Medical Information Exchange (AMIE) worksheet compliance. Each contractor's Quality Analysis staff completes a review prior to releasing the examination for RO use. If the RO finds a problem with the completed examination, they notify the contractor and the C&P Service Contract Exam staff. The contractor will have the sub-contractor fix the issue, and the Contract Exam staff will request retraining of the examiner on the particular issue. If the situation arises again after retraining has been attempted, the contractor is asked not to use the examiner again.

Question 17. What actions does VA take when non-compliance with VA policy or procedure is identified?

Response. When VBA finds that contracted medical disability exams were not compliant with VA policy and procedures, the contractor is instructed to cease sending Veterans to the sub-contractor for C&P examinations.

Question 18. How many examiners were identified during the past three years which resulted in VHA taking corrective action, such as performance improvement plans?

Response. The CPEP exam review process is used as an aggregated measure of performance, tracked by exam type and rolled-up at the VISN level for performance measure tracking. Between 700–800 unique examiners are evaluated each month through random sampling of C&P examinations. CPEP releases individual examination report scores, which can be used by medical center management to identify and address specific performance issues. However, there is no centralized authority for remediation or tracking of individual performance-related actions at VHA field sites.

Recognizing this is an issue, VHA is in the process of re-examining the CPEP Program with the intent of re-designing the quality review process to incorporate field-based peer reviews, larger numbers of monthly reviews, and the ability to identify deficits and implement a central remediation program. Implementation of this change should begin within the next calendar year.

CPEP has addressed the issue of improving provider performance through multiple education strategies. Over the past three years, CPEP has conducted three multi-day training conferences (attended by VBA and VHA staff) and a number of regional and local training sessions. CPEP evaluates approximately 160–300 monthly requests for scoring appeals, which serves as an educational tool through the appeals feedback mechanism. In addition, the CPEP examination quality and timeliness scores are part of the VISN and medical center leadership's performance plan.

CPEP reporting demonstrates improvement from around 40 percent for the quality review scores in 2003 to a high of above 90 percent approximately 3 years ago. It is recognized that, although there has been significant improvement, a plateau has been reached and changes to the review process and educational efforts must be instituted. CPEP's educational material is under evaluation with new training modules in development for Muskuloskeletal, General Medical and Foot examination types. Audiology is being evaluated as a fourth training module effort. ATraumatic Brain Injury module has been activated within the past 45 days.

Question 19. How does VA determine and monitor the amount of time needed to conduct compensation and pension examinations?

Response. For C&P medical disability examination contracts, times are based on the Current Procedural Terminology (CPT) codes. The following codes are used to report evaluation and management services provided in the physician's office or in an outpatient clinic: 99203: 30 minutes, 99204: 45 minutes, and 99205: 60 minutes. An initial post-traumatic stress disability examination time of 90 minutes is built into the contracts. C&P MDEs take more time than standard medical exams due to their complexity.

Question 20. Provide a list of the amount and percentage of budget allocated to the conduct of compensation and pension examinations in each VISN, broken down by VA and local contractors.

Response. The information below covers medical disability examination contracts administered by C&P Service.

Table 2.—FY 2009 Expenditures at QTC Sites

VISN	%	Amount
Boston (VISN 1)	1.6	$1,778,348
Roanoke (VISN 6)	13.5	15,004,813
Winston-Salem (VISN 6)	11.1	12,337,290
Atlanta (VISN 7)	13.2	14,671,372
Muskogee (VISN 16)	12.5	13,893,345
Houston (VISN 16)	12.8	14,226,785
Salt Lake City (VISN 19)	1.5	1,667,201
Seattle (VISN 20)	10.9	12,114,997
Los Angeles (VISN 22)	5.5	6,113,072
San Diego (VISN 22)	8.4	9,336,328
Louisville (VISN 9)	0.8	889,174
Nashville (VISN 9)	0.5	555,734
St. Petersburg (VISN 8)	2.4	2,667,522
Waco (VISN 17)	0.3	333,440
Phoenix (VISN 18)	2.9	3,167,683
St. Paul (VISN 23)	0.1	111,147
Lincoln (VISN 23)	2.0	2,222,935
Total	100.0	$111,091,188

Table 3.—FY 2009 Expenditures at MES Sites

VISN	%	Amount
Cleveland (VISN 10)	9.6	$1,002,319
Indianapolis (VISN 11)	23.3	2,438,242
Des Moines (VISN 23)	1.8	192,713

Table 3.—FY 2009 Expenditures at MES Sites—Continued

VISN	%	Amount
Lincoln (VISN 23)	7.8	821,126
St. Louis (VISN 15)	19.0	1,993,116
Waco (VISN 17)	38.4	4,022,890
Total	100.0	$10,470,406

Question 21. How does VA determine and monitor the amount of time needed to conduct compensation and pension examinations?

Response. Please see the response to #19.

Question 22. At the hearing, Mr. Baker said that the total amount VA spent on outside providers last year, including all health services, was $3 billion. Does this number include all contract and fee basis services, including Project HERO?

Response. Yes, the $3 billion number Mr. Baker quoted is the FY 2008 amount VA spent on outside providers, including Fee Basis and Project HERO care paid for through the VistA Fee claims processing system. By comparison, FY 2009 expenditures were approximately $3.8 billion.

Question 23. Project HERO been described in the media as a $915 million project. What is the total amount of money spent on Project HERO annually since its inception?

Response. The $915 million described in the media at the inception of the Project HERO contracts was an approximation of the maximum amount that would be spent for care services purchased through the Humana Veterans Healthcare Services award over a five-year contract period.

The following tables show the actual amount of dollars disbursed on Project HERO annually since its inception in FY 2008.

Delta Dental

VISN	Disbursed dollars for health care FY08	Disbursed dollars for health care FY09 through Aug 09	Disbursed dollars for health care Subtotal	Value-added fees FY08	Value-added fees FY09 through Aug 09	Value-added fees Subtotal	Disbursed dollars for health care and value-added fees FY08	Disbursed dollars for health care and value-added fees FY09 through Aug 09	Grand total
VISN 08	$ 423,925.90	$ 2,726,311.62	$ 3,150,237.52	$ 54,252.27	$ 220,092.21	$ 274,344.48	$ 478,178.17	$ 2,946,403.83	$ 3,424,582.00
VISN 16	$ 624,659.85	$ 3,558,804.06	$ 4,183,463.93	$ 58,363.11	$ 321,294.60	$ 379,657.71	$ 683,022.96	$ 3,880,098.68	$ 4,563,121.64
VISN 20	$ 344,264.57	$ 1,385,348.63	$ 1,729,613.20	$ 34,617.60	$ 114,238.08	$ 148,855.68	$ 378,882.17	$ 1,499,586.71	$ 1,878,468.88
VISN 23	$ 453,124.35	$ 3,812,391.45	$ 4,265,515.80	$ 84,218.13	$ 321,024.15	$ 405,242.28	$ 537,342.48	$ 4,133,415.60	$ 4,670,758.08
Grand Total	$ 1,845,974.67	$11,482,855.78	$13,328,830.45	$ 231,451.11	$ 976,649.04	$ 1,208,100.15	$ 2,077,425.78	$12,459,504.82	$14,536,930.60

HVHS

VISN	Disbursed dollars for health care FY08	Disbursed dollars for health care FY09 through Aug 09	Disbursed dollars for health care Subtotal	Value-added fees FY08	Value-added fees FY09 through Aug 09	Value-added fees Subtotal	Disbursed dollars for health care and value-added fees FY08	Disbursed dollars for health care and value-added fees FY09 through Aug 09	Grand total
VISN 08	$ 2,036,065.99	$13,629,038.16	$15,665,104.17	$ 3,757.20	$ 804,025.07	$ 807,782.27	$ 2,039,823.19	$14,433,063.25	$16,472,886.44
VISN 16	$ 1,864,005.45	$12,780,317.95	$14,644,323.40		$ 1,270,924.78	$ 1,270,924.78	$ 1,864,005.45	$14,051,242.73	$15,915,248.18
VISN 20	$ 980,815.45	$ 2,964,508.61	$ 3,945,324.06	$ 64,558.40	$ 387,708.89	$ 452,267.29	$ 1,045,373.85	$ 3,352,217.50	$ 4,397,591.35
VISN 23	$ 342,535.08	$ 4,134,372.24	$ 4,476,907.32	$ 773.68	$ 429,327.96	$ 430,101.64	$ 343,308.76	$ 4,563,700.20	$ 4,907,008.96
Grand Total	$ 5,223,421.97	$33,508,236.98	$38,731,658.95	$ 69,089.28	$ 2,891,986.70	$ 2,961,075.98	$ 5,292,511.25	$36,400,223.68	$41,692,734.93

Sources: VSSC Non-VA Care cube was used for disbursed dollars for healthcare, and HVHS and Delta Dental report directly on value-added fees invoiced.

Question 24. How many providers, by specialty and location, have agreed to provide services to veterans through Project HERO?

Response. (See Attachment 1 with Delta Federal Services and Attachment 2 with detailed lists for Humana Veterans Healthcare, which follow).

ATTACHMENT 1 FOR QUESTION 24

Delta Dental Insurance Company					
Project HERO Dental Program					
Credentialed Providers by VA Medical Center					
As of: October 16, 2009					
VISN	Station	Location	Spec	Specialty	Count
8	516	Bay Pines, FL	000	General Practioner	157
			010	Oral Surgeon	34
			015	Endodontist	27
			020	Orthodontist	7
			030	Pediatric Dentist	0
			040	Periodontist	30
			050	Prosthodontist	3
				Total	**258**
8	546	Miami	000	General Practioner	43
			010	Oral Surgeon	0
			015	Endodontist	18
			020	Orthodontist	0
			030	Pediatric Dentist	0
			040	Periodontist	6
			050	Prosthodontist	1
				Total	**68**
8	548	West Palm Beach	000	General Practioner	113
			010	Oral Surgeon	3
			015	Endodontist	40
			020	Orthodontist	2
			030	Pediatric Dentist	0
			040	Periodontist	10
			050	Prosthodontist	2
				Total	**170**
8	573	North FL, South GA	000	General Practioner	247
			010	Oral Surgeon	55
			015	Endodontist	44

			020	Orthodontist		24
			030	Pediatric Dentist		0
			040	Periodontist		26
			050	Prosthodontist		6
				Total		**402**
8	673	Tampa	000	General Practioner		138
			010	Oral Surgeon		14
			015	Endodontist		21
			020	Orthodontist		13
			030	Pediatric Dentist		0
			040	Periodontist		32
			050	Prosthodontist		4
				Total		**222**
8	675	Orlando	000	General Practioner		630
			010	Oral Surgeon		122
			015	Endodontist		52
			020	Orthodontist		72
			030	Pediatric Dentist		0
			040	Periodontist		83
			050	Prosthodontist		13
				Total		**972**
VISN 8			000	General Practioner		1,328
			010	Oral Surgeon		228
			015	Endodontist		202
			020	Orthodontist		118
			030	Pediatric Dentist		0
			040	Periodontist		187
			050	Prosthodontist		29
VISN 8 Total						**2,092**
16	502	Alexandria	000	General Practioner		23
			010	Oral Surgeon		3
			015	Endodontist		0
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		0
				Total		**26**

16	520	Biloxi, MS	000	General Practioner		131
			010	Oral Surgeon		30
			015	Endodontist		9
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		5
			050	Prosthodontist		2
				Total		**177**
16	564	Fayetteville,AR	000	General Practioner		127
			010	Oral Surgeon		21
			015	Endodontist		3
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		1
			050	Prosthodontist		0
				Total		**152**
16	568	Black Hills, SD	000	General Practioner		17
			010	Oral Surgeon		7
			015	Endodontist		0
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		0
				Total		**24**
16	580	Houston	000	General Practioner		30
			010	Oral Surgeon		2
			015	Endodontist		5
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		1
				Total		**38**
16	586	Jackson, MS	000	General Practioner		11
			010	Oral Surgeon		0
			015	Endodontist		1
			020	Orthodontist		0
			030	Pediatric Dentist		0

			040		Periodontist	0
			050		Prosthodontist	0
					Total	**12**
16	598	Little Rock, AK	000		General Practioner	187
			010		Oral Surgeon	8
			015		Endodontist	3
			020		Orthodontist	0
			030		Pediatric Dentist	0
			040		Periodontist	6
			050		Prosthodontist	0
					Total	**204**
16	623	Muskogee, OK	000		General Practioner	139
			010		Oral Surgeon	9
			015		Endodontist	5
			020		Orthodontist	0
			030		Pediatric Dentist	0
			040		Periodontist	0
			050		Prosthodontist	1
					Total	**154**
16	629	New Orleans	000		General Practioner	30
			010		Oral Surgeon	9
			015		Endodontist	1
			020		Orthodontist	0
			030		Pediatric Dentist	0
			040		Periodontist	0
			050		Prosthodontist	0
					Total	**40**
16	635	Oklahoma City, OK	000		General Practioner	370
			010		Oral Surgeon	14
			015		Endodontist	16
			020		Orthodontist	2
			030		Pediatric Dentist	0
			040		Periodontist	3
			050		Prosthodontist	5
					Total	**410**
16	667	Shreveport, LA	000		General Practioner	65
			010		Oral Surgeon	13

			015	Endodontist		1
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		0
				Total		**79**
VISN 16			000	General Practioner		1,130
			010	Oral Surgeon		116
			015	Endodontist		44
			020	Orthodontist		2
			030	Pediatric Dentist		0
			040	Periodontist		15
			050	Prosthodontist		9
VISN 16 Total						**1,316**
20	531	Boise, ID	000	General Practioner		15
			010	Oral Surgeon		1
			015	Endodontist		0
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		1
			050	Prosthodontist		0
				Total		**17**
20	648	Portland, OR	000	General Practioner		148
			010	Oral Surgeon		2
			015	Endodontist		11
			020	Orthodontist		8
			030	Pediatric Dentist		0
			040	Periodontist		8
			050	Prosthodontist		2
				Total		**179**
20	653	Roseburg, OR	000	General Practioner		69
			010	Oral Surgeon		11
			015	Endodontist		3
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		4
			050	Prosthodontist		1

				Total	**88**
20	663	Puget Sound, WA	000	General Practioner	400
			010	Oral Surgeon	26
			015	Endodontist	17
			020	Orthodontist	14
			030	Pediatric Dentist	0
			040	Periodontist	24
			050	Prosthodontist	1
				Total	**482**
20	668	Spokane, WA	000	General Practioner	71
			010	Oral Surgeon	20
			015	Endodontist	5
			020	Orthodontist	0
			030	Pediatric Dentist	0
			040	Periodontist	1
			050	Prosthodontist	1
				Total	**98**
20	687	Walla Walla, WA	000	General Practioner	35
			010	Oral Surgeon	5
			015	Endodontist	7
			020	Orthodontist	0
			030	Pediatric Dentist	0
			040	Periodontist	0
			050	Prosthodontist	0
				Total	**47**
20	692	White City, OR	000	General Practioner	23
			010	Oral Surgeon	12
			015	Endodontist	4
			020	Orthodontist	0
			030	Pediatric Dentist	0
			040	Periodontist	0
			050	Prosthodontist	1
				Total	**40**
VISN 20			000	General Practioner	761
			010	Oral Surgeon	77
			015	Endodontist	47
			020	Orthodontist	22

			030	Pediatric Dentist		0
			040	Periodontist		38
			050	Prosthodontist		6
VISN 20 Total						**951**
23	437	Fargo, ND	000	General Practioner		98
			010	Oral Surgeon		4
			015	Endodontist		1
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		0
				Total		**103**
23	438	Sioux Falls, SD	000	General Practioner		101
			010	Oral Surgeon		31
			015	Endodontist		7
			020	Orthodontist		2
			030	Pediatric Dentist		0
			040	Periodontist		4
			050	Prosthodontist		0
				Total		**145**
23	618	Minneapolis, MN	000	General Practioner		3,712
			010	Oral Surgeon		177
			015	Endodontist		90
			020	Orthodontist		56
			030	Pediatric Dentist		0
			040	Periodontist		37
			050	Prosthodontist		26
				Total		**4,098**
23	636	NWI Grand Island & Lincoln DIV, NE	000	General Practioner		74
			010	Oral Surgeon		15
			015	Endodontist		0
			020	Orthodontist		0
			030	Pediatric Dentist		0
			040	Periodontist		0
			050	Prosthodontist		0
				Total		**89**
23	656	St. Cloud	000	General Practioner		248

			010		Oral Surgeon	49
			015		Endodontist	8
			020		Orthodontist	0
			030		Pediatric Dentist	0
			040		Periodontist	3
			050		Prosthodontist	2
					Total	**310**
VISN 23			000		General Practioner	4,233
			010		Oral Surgeon	276
			015		Endodontist	106
			020		Orthodontist	58
			030		Pediatric Dentist	0
			040		Periodontist	44
			050		Prosthodontist	28
VISN 23 Total						**4,745**
		Not Participating	000		General Practioner	171
			010		Oral Surgeon	13
			015		Endodontist	2
			020		Orthodontist	1
			030		Pediatric Dentist	0
			040		Periodontist	2
			050		Prosthodontist	1
VISN 00		**Total**				**190**
			000		General Practioner	7,623
			010		Oral Surgeon	710
			015		Endodontist	401
			020		Orthodontist	201
			030		Pediatric Dentist	0
			040		Periodontist	286
			050		Prosthodontist	73
Grand Total						**9,294**

ATTACHMENT 2 FOR QUESTION 24

Humana Veterans Healthcare Services Provider Network 10/20/09			
VISN	**Catchment**	**Specialty**	**Provider Network Total**
8	Bay Pines	Allergy	1
		Ambulatory Surgical Center	16
		Anesthesiology	5
		Audiology	2
		Cardiovascular Disease	40
		Chiropractor, Licensed	1
		Dermatology	18
		Dermatology - MOHS Surgery	3
		Endocrinologists	2
		Family Practice	16
		Freestanding Imaging Facility	9
		Gastroenterology	7
		General Surgery	52
		Gynecologic Oncology	1
		Gynecology (Osteopaths)	1
		Independent Laboratory	12
		Internal Medicine	83
		Kidney Centers	5
		Long Term General Hospital	1
		Marriage and Family Counselor	13
		Mental Health Counselor	67
		Nephrology	41
		Neurological Surgery	11
		Neurology	18
		Neuroradiology	2
		OB/GYN	13
		Occupational Therapy	63
		Oncology	20
		Ophthalmology	69
		Ophthalmology, Otology, Lary. & Rhin	2
		Optometrist	36
		Orthopedic Surgery	25
		Otology, Laryngology &	3

		Rhinology	
		Pain Management	13
		Pathology	1
		Physical Medicine & Rehabilitation	12
		Physical Therapist	166
		Plastic Surgery	2
		Podiatry	10
		Psychiatric	1
		Psychiatry	3
		Psychiatry, Neurology (Osteopaths Only)	3
		Psychologists	43
		Pulmonary Disease	13
		Radiation Oncology	125
		Radiology	110
		Rehabilitation	3
		Rheumatology	2
		Short Term General Hospital	16
		Sleep Disorders	3
		Social Worker (MSW, ASW)	55
		Speech Pathologist/Speech Therapist	4
		Thoracic and Cardiovascular Surgery	10
		Thoracic and Vascular Surgery	1
		Thoracic Surgery	24
		Thoracic, Cardiovascular, Vascular Surge	18
		Urology	105
		Vascular and Interventional Radiology	1
		Vascular Surgery	21
		Wound Care	2
	Bay Pines Total		1,425
	Miami	Allergy	20
		Ambulatory Surgical Center	7
		Anesthesiology	5
		Audiology	12
		Cardiovascular Disease	44
		Dermatology	72
		Dermatology - MOHS Surgery	7
		Endocrinologists	2
		Freestanding Imaging Facility	9

		Gastroenterology	7
		General Surgery	13
		Hand Surgery	1
		Hematology	1
		Independent Laboratory	20
		Infectious Disease	3
		Internal Medicine	28
		Kidney Centers	9
		Manipulative Therapy (Osteopaths Only)	1
		Marriage and Family Counselor	19
		Mental Health Counselor	108
		Nephrology	8
		Neurological Surgery	9
		Neurology	18
		Nuclear Medicine	5
		OB/GYN	18
		Occupational Therapy	16
		Oncology	31
		Ophthalmology	46
		Optometrist	1
		Orthopedic Surgery	20
		Otology, Laryngology & Rhinology	84
		Pain Management	1
		Pathology	5
		Physical Medicine & Rehabilitation	2
		Physical Therapist	146
		Plastic Surgery	3
		Podiatry	13
		Psychiatry	59
		Psychologists	157
		Pulmonary Disease	6
		Radiation Oncology	5
		Radiology	70
		Rehabilitation	5
		Short Term General Hospital	21
		Social Worker (MSW, ASW)	121
		Substance Abuse Counselor	1
		Thoracic Surgery	6
		Urology	20
		Vascular Surgery	1
	Miami Total		1,286

	North Florida/South Georgia	Allergy	5
		Ambulatory Surgical Center	11
		Anesthesiology	32
		Audiology	4
		Cardiovascular Disease	31
		Certified Reg. Nurse Anesthetist (CRNA)	44
		Dermatology	14
		Dermatology - MOHS Surgery	1
		Endocrinologists	17
		Family Practice	10
		Freestanding Imaging Facility	12
		Gastroenterology	27
		General Surgery	49
		Geriatrics	7
		Gynecologic Oncology	5
		Gynecology (Osteopaths)	1
		Hematology	1
		Independent Laboratory	18
		Infectious Disease	8
		Internal Medicine	158
		Interventional Cardiology	3
		Kidney Centers	1
		Long Term Special Hospital	1
		Marriage and Family Counselor	15
		Mental Health Counselor	68
		Nephrology	11
		Neurological Surgery	12
		Neurology	26
		Neuroradiology	2
		Nuclear Medicine	11
		OB/GYN	38
		Occupational Therapy	3
		Oncology	91
		Ophthalmology	18
		Optometrist	3
		Orthopedic Surgery	63
		Otology, Laryngology & Rhinology	8
		Pain Management	10
		Pathology	39
		Physical Medicine &	15

		Rehabilitation	
		Physical Therapist	53
		Plastic Surgery	8
		Podiatry	24
		Psychiatric	4
		Psychiatry	18
		Psychologists	32
		Pulmonary and Critical Care	6
		Pulmonary Disease	22
		Radiation Oncology	181
		Radiology	217
		Rehabilitation	1
		Reproductive Endocrinology	2
		Rheumatology	11
		Short Term General Hospital	20
		Sleep Disorders	3
		Social Worker (MSW, ASW)	38
		Substance Abuse Counselor	3
		Thoracic and Cardiovascular Surgery	2
		Thoracic Surgery	2
		Thoracic, Cardiovascular, Vascular Surge	3
		Urology	8
		Vascular and Interventional Radiology	2
		Vascular Surgery	9
	North Florida/South Georgia Total		1,562
	Orlando	Acupuncture (Non-Physician)	1
		Allergy	3
		Ambulatory Surgical Center	15
		Audiology	5
		Cardiovascular Disease	56
		Chiropractor, Licensed	3
		Dermatology	47
		Freestanding Imaging Facility	12
		Gastroenterology	38
		General Practice	2
		General Surgery	12
		Independent Laboratory	5
		Infectious Disease	1
		Internal Medicine	109
		Kidney Centers	9

		Marriage and Family Counselor	11
		Mental Health Counselor	112
		Nephrology	36
		Neurological Surgery	3
		Neurology	17
		Neuroradiology	1
		Nuclear Medicine	1
		OB/GYN	2
		Occupational Therapy	26
		Oncology	12
		Ophthalmology	44
		Optometrist	23
		Orthopedic Surgery	7
		Otology, Laryngology & Rhinology	2
		Pain Management	18
		Pathology	2
		Physical Medicine & Rehabilitation	11
		Physical Therapist	142
		Plastic Surgery	1
		Podiatry	28
		Psychiatric	1
		Psychiatry	31
		Psychologists	24
		Pulmonary Disease	14
		Radiation Oncology	21
		Radiology	247
		Rehabilitation	1
		Rheumatology	1
		Short Term General Hospital	2
		Sleep Disorders	7
		Social Worker (MSW, ASW)	56
		Speech Pathologist/Speech Therapist	2
		Thoracic and Cardiovascular Surgery	2
		Thoracic Surgery	3
		Thoracic, Cardiovascular, Vascular Surge	3
		Urology	11
		Vascular Surgery	4
	Orlando Total		1,247

	Tampa	Acupuncture (Non-Physician)	1
		Allergy	8
		Ambulatory Surgical Center	8
		Anesthesiology	17
		Audiology	8
		Cardiovascular Disease	41
		Certified Reg. Nurse Anesthetist (CRNA)	26
		Chiropractor, Licensed	1
		Dermatology	48
		Dermatology - MOHS Surgery	15
		Endocrinologists	4
		Family Practice	11
		Freestanding Imaging Facility	13
		Gastroenterology	21
		General Practice	1
		General Surgery	53
		Geriatrics	3
		Gynecologic Oncology	4
		Hand Surgery	2
		Hematology	23
		Independent Laboratory	3
		Infectious Disease	13
		Internal Medicine	61
		Internal Medicine, Hospital Only	2
		Interventional Cardiology	3
		Marriage and Family Counselor	10
		Mental Health Counselor	81
		Nephrology	20
		Neurological Surgery	15
		Neurology	32
		Neuroradiology	1
		Nuclear Medicine	3
		OB/GYN	40
		Occupational Medicine	1
		Occupational Therapy	121
		Oncology	55
		Ophthalmology	52
		Ophthalmology-Retina Specialist	1
		Optometrist	61
		Orthopedic Surgery	12
		Otology, Laryngology &	16

		Rhinology	
		Pain Management	11
		Pathology	39
		Pathology/Clinical Path (Osteo Only)	1
		Physical Medicine & Rehabilitation	1
		Physical Therapist	401
		Plastic Surgery	6
		Podiatry	39
		Psychiatric	2
		Psychiatry	38
		Psychologists	31
		Pulmonary and Critical Care	3
		Pulmonary Disease	9
		Radiation Oncology	7
		Radiology	117
		Rehabilitation	1
		Reproductive Endocrinology	3
		Rheumatology	9
		Short Term General Hospital	14
		Social Worker (MSW, ASW)	43
		Speech Pathologist/Speech Therapist	2
		Sports Medicine	1
		Thoracic and Cardiovascular Surgery	3
		Thoracic Surgery	14
		Thoracic, Cardiovascular, Vascular Surge	5
		Urology	14
		Vascular and Interventional Radiology	3
		Vascular Surgery	8
	Tampa Total		1,736
	West Palm Beach	Allergy	2
		Ambulatory Surgical Center	10
		Anesthesiology	1
		Audiology	104
		Cardiovascular Disease	10
		Dermatology	56
		Dermatology - MOHS Surgery	12
		Family Practice	9
		Freestanding Imaging Facility	7

		Gastroenterology	6
		General Practice	2
		General Surgery	1
		Independent Laboratory	1
		Internal Medicine	22
		Marriage and Family Counselor	10
		Mental Health Counselor	62
		Nephrology	1
		Neurological Surgery	1
		Neurology	7
		Nuclear Medicine	7
		OB/GYN	1
		Occupational Therapy	1
		Oncology	1
		Ophthalmology	31
		Optometrist	3
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	4
		Pain Management	1
		Pathology	8
		Physical Medicine & Rehabilitation	1
		Physical Therapist	20
		Plastic Surgery	1
		Podiatry	15
		Psychiatric	1
		Psychiatry	10
		Psychologists	27
		Pulmonary Disease	3
		Radiation Oncology	29
		Radiology	192
		Rehabilitation	1
		Short Term General Hospital	6
		Sleep Disorders	7
		Social Worker (MSW, ASW)	70
		Substance Abuse Counselor	2
		Thoracic Surgery	5
		Urology	3
	West Palm Beach Total		775
8 Total			8,031
16	Alexandria	Allergy	1
		Ambulatory Surgical Center	3

		Anesthesiology	4
		Cardiovascular Disease	19
		Chiropractor, Licensed	4
		Dermatology	1
		Freestanding Imaging Facility	8
		Gastroenterology	1
		General Practice	1
		General Surgery	5
		Geriatrics	1
		Gynecology (Osteopaths)	1
		Hematology	5
		Hyperbaric Medicine	3
		Independent Laboratory	1
		Internal Medicine	48
		Kidney Centers	5
		Long Term General Hospital	2
		Marriage and Family Counselor	12
		Mental Health Counselor	23
		Nephrology	14
		Neurological Surgery	3
		Neurology	2
		Nuclear Medicine	1
		OB/GYN	7
		Occupational Therapy	2
		Oncology	9
		Ophthalmology	8
		Optometrist	11
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	6
		Pathology	19
		Physical Medicine & Rehabilitation	1
		Physical Therapist	9
		Podiatry	5
		Psychiatric	2
		Psychiatry	4
		Psychologists	7
		Pulmonary Disease	4
		Radiation Oncology	1
		Radiology	29
		Rheumatology	1
		Short Term General Hospital	20
		Sleep Disorders	7

		Social Worker (MSW, ASW)	15
		Speech Pathologist/Speech Therapist	4
		Thoracic and Cardiovascular Surgery	4
		Thoracic Surgery	4
		Urology	1
		Vascular Surgery	1
16	Alexandria Total		350
16	Fayetteville	Allergy	6
		Ambulatory Surgical Center	13
		Anesthesiology	32
		Audiology	2
		Bariatric Surgery	1
		Cardiovascular Disease	35
		Certified Reg. Nurse Anesthetist (CRNA)	20
		Chiropractor, Licensed	21
		Dermatology	9
		Dermatology - MOHS Surgery	3
		Endocrinologists	1
		Family Practice	16
		Freestanding Imaging Facility	9
		Gastroenterology	14
		General Practice	1
		General Surgery	44
		Geriatrics	10
		Hand Surgery	1
		Hematology	4
		Independent Laboratory	8
		Infectious Disease	2
		Internal Medicine	58
		Internal Medicine, Hospital Only	1
		Kidney Centers	6
		Long Term General Hospital	2
		Manipulative Therapy (Osteopaths Only)	1
		Marriage and Family Counselor	4
		Mental Health Counselor	35
		Nephrology	12
		Neurological Surgery	21
		Neurology	2

		OB/GYN	33
		Occupational Medicine	2
		Occupational Therapy	3
		Oncology	11
		Ophthalmology	28
		Ophthalmology-Glaucoma Specialist	3
		Ophthalmology-Retina Specialist	2
		Optometrist	45
		Orthopedic Surgery	14
		Otology, Laryngology & Rhinology	10
		Pain Management	4
		Pathology	14
		Physical Medicine & Rehabilitation	17
		Physical Therapist	23
		Plastic Surgery	1
		Podiatry	20
		Psychiatric	1
		Psychiatry	10
		Psychologists	44
		Pulmonary and Critical Care	1
		Pulmonary Disease	19
		Radiology	63
		Rehabilitation	2
		Rheumatology	1
		Short Term General Hospital	13
		Sleep Disorders	1
		Social Worker (MSW, ASW)	11
		Thoracic and Vascular Surgery	8
		Thoracic, Cardiovascular, Vascular Surge	10
		Urology	12
		Vascular and Interventional Radiology	1
16	Fayetteville Total		821
16	Gulf Coast (Biloxi)	Allergy	1
		Ambulatory Surgical Center	13
		Anesthesiology	35
		Audiology	6
		Cardiac Rehabilitation	1
		Cardiovascular Disease	23

		Certified Reg. Nurse Anesthetist (CRNA)	5
		Chiropractor, Licensed	3
		Dermatology	9
		Dermatology - MOHS Surgery	1
		Endocrinologists	4
		Family Practice	3
		Freestanding Imaging Facility	13
		Gastroenterology	20
		General Surgery	17
		Gynecologic Oncology	1
		Hand Surgery	1
		Hematology	3
		Independent Laboratory	5
		Infectious Disease	7
		Internal Medicine	74
		Kidney Centers	1
		Long Term General Hospital	1
		Marriage and Family Counselor	3
		Mental Health Counselor	43
		Nephrology	19
		Neurological Surgery	21
		Neurology	9
		Neuro-Ophthalmology	1
		Nuclear Medicine	3
		OB/GYN	22
		Occupational Therapy	22
		Oncology	16
		Ophthalmology	46
		Ophthalmology-Glaucoma Specialist	2
		Ophthalmology-Retina Specialist	18
		Optometrist	20
		Orthopedic Surgery	45
		Otology, Laryngology & Rhinology	3
		Pain Management	13
		Pathology	16
		Physical Medicine & Rehabilitation	1
		Physical Therapist	115
		Plastic Surgery	3
		Podiatry	13

		Psychiatric	2
		Psychiatry	7
		Psychologists	9
		Pulmonary Disease	13
		Radiation Oncology	7
		Radiology	116
		Rehabilitation	1
		Reproductive Endocrinology	1
		Rheumatology	4
		Short Term General Hospital	28
		Sleep Disorders	9
		Social Worker (MSW, ASW)	14
		Speech Pathologist/Speech Therapist	1
		Thoracic Surgery	1
		Urology	14
		Vascular Surgery	1
	Gulf Coast (Biloxi) Total		929
	Houston	Acupuncture (Non-Physician)	1
		Allergy	22
		Ambulatory Surgical Center	9
		Anesthesiology	1
		Cardiovascular Disease	20
		Certified Surgical Assistant	1
		Chiropractor, Licensed	3
		Dermatology	5
		Diagnostic Radiology	1
		Endocrinologists	15
		Freestanding Imaging Facility	5
		Gastroenterology	25
		General Surgery	13
		Hand Surgery	4
		Hematology	2
		Independent Laboratory	48
		Infectious Disease	1
		Internal Medicine	33
		Interventional Cardiology	3
		Kidney Centers	4
		Marriage and Family Counselor	25
		Mental Health Counselor	218
		Nephrology	24
		Neurological Surgery	1

		Neurology	7
		Neuro-Ophthalmology	1
		OB/GYN	33
		Occupational Therapy	41
		Oncology	3
		Ophthalmology	70
		Ophthalmology, Otology, Lary. & Rhin	2
		Ophthalmology-Glaucoma Specialist	10
		Ophthalmology-Retina Specialist	7
		Optometrist	1
		Orthopedic Surgery	77
		Otology, Laryngology & Rhinology	28
		Pain Management	5
		Physical Medicine & Rehabilitation	2
		Physical Therapist	137
		Plastic Surgery	2
		Podiatry	2
		Psychiatric	1
		Psychiatry	46
		Psychologists	72
		Pulmonary Disease	3
		Radiation Oncology	1
		Radiology	66
		Rehabilitation	2
		Rheumatology	2
		Short Term General Hospital	22
		Social Worker (MSW, ASW)	77
		Sports Medicine	2
		Substance Abuse Counselor	3
		Thoracic Surgery	12
		Urology	30
	Houston Total		1,251
	Jackson	Allergy	6
		Ambulatory Surgical Center	7
		Anesthesiology	11
		Cardiovascular Disease	25
		Certified Reg. Nurse Anesthetist (CRNA)	4
		Chiropractor, Licensed	1

		Dermatology	2
		Family Practice	29
		Freestanding Imaging Facility	5
		Gastroenterology	47
		General Surgery	19
		Independent Laboratory	20
		Infectious Disease	1
		Internal Medicine	56
		Long Term General Hospital	3
		Mental Health Counselor	7
		Nephrology	12
		Neurological Surgery	5
		Neurology	6
		Nuclear Medicine	2
		OB/GYN	8
		Ophthalmology	35
		Ophthalmology, Otology, Lary. & Rhin	1
		Ophthalmology-Glaucoma Specialist	3
		Ophthalmology-Retina Specialist	4
		Orthopedic Surgery	16
		Otology, Laryngology & Rhinology	7
		Pain Management	12
		Pathology	3
		Physical Medicine & Rehabilitation	2
		Physical Therapist	4
		Plastic Surgery	4
		Podiatry	2
		Psychiatry	1
		Pulmonary and Critical Care	1
		Pulmonary Disease	15
		Radiation Oncology	6
		Radiology	7
		Rheumatology	2
		Short Term General Hospital	19
		Sleep Disorders	1
		Social Worker (MSW, ASW)	5
		Thoracic and Cardiovascular Surgery	1
		Thoracic Surgery	2
		Urology	10

		Vascular Surgery	1
	Jackson Total		440
	Little Rock	Allergy	4
		Ambulatory Surgical Center	7
		Anesthesiology	31
		Audiology	7
		Cardiovascular Disease	18
		Certified Reg. Nurse Anesthetist (CRNA)	17
		Chiropractor, Licensed	2
		Dermatology	14
		Dermatology - MOHS Surgery	2
		Endocrinologists	8
		Family Practice	7
		Freestanding Imaging Facility	3
		Gastroenterology	22
		General Practice	2
		General Surgery	41
		Geriatrics	25
		Gynecology (Osteopaths)	1
		Hand Surgery	1
		Hematology	3
		Hyperbaric Medicine	7
		Independent Laboratory	12
		Infectious Disease	10
		Internal Medicine	90
		Kidney Centers	8
		Marriage and Family Counselor	7
		Mental Health Counselor	50
		Nephrology	12
		Neurological Surgery	8
		Neurology	14
		Neuro-Ophthalmology	1
		Nuclear Medicine	14
		OB/GYN	26
		Occupational Therapy	6
		Oncology	12
		Ophthalmology	41
		Ophthalmology-Glaucoma Specialist	3
		Ophthalmology-Retina Specialist	1
		Optometrist	4

		Orthopedic Surgery	43
		Otology, Laryngology & Rhinology	16
		Pain Management	1
		Pathology	26
		Pathology/Clinical Path (Osteo Only)	7
		Physical Medicine & Rehabilitation	8
		Physical Therapist	68
		Plastic Surgery	4
		Podiatry	18
		Psychiatry	19
		Psychologists	31
		Pulmonary Disease	20
		Radiation Oncology	1
		Radiology	76
		Rehabilitation	1
		Rheumatology	3
		Short Term General Hospital	11
		Social Worker (MSW, ASW)	58
		Sports Medicine	2
		Thoracic and Cardiovascular Surgery	2
		Thoracic and Vascular Surgery	2
		Thoracic Surgery	4
		Thoracic, Cardiovascular, Vascular Surge	1
		Urology	9
		Vascular and Interventional Radiology	8
		Wound Care	1
	Little Rock Total		981
	Muskogee	Ambulatory Surgical Center	5
		Anesthesiology	5
		Audiology	1
		Cardiovascular Disease	26
		Certified Reg. Nurse Anesthetist (CRNA)	12
		Chiropractor, Licensed	1
		Dermatology	2
		Endocrinologists	1
		Family Practice	14
		Freestanding Imaging Facility	7

		Gastroenterology	23
		General Surgery	15
		Geriatrics	2
		Hematology	5
		Independent Laboratory	6
		Internal Medicine	85
		Kidney Centers	1
		Long Term General Hospital	1
		Marriage and Family Counselor	10
		Mental Health Counselor	15
		Nephrology	5
		Neurological Surgery	1
		Neuroradiology	1
		Nuclear Medicine	6
		OB/GYN	20
		Occupational Medicine	1
		Oncology	12
		Ophthalmology	17
		Ophthalmology-Glaucoma Specialist	2
		Optometrist	18
		Orthopedic Surgery	10
		Otology, Laryngology & Rhinology	3
		Pain Management	4
		Pathology	2
		Physical Medicine & Rehabilitation	3
		Physical Therapist	252
		Podiatry	1
		Psychiatric	2
		Psychiatry	8
		Psychologists	15
		Pulmonary Disease	6
		Radiation Oncology	1
		Radiology	47
		Rheumatology	1
		Short Term General Hospital	15
		Sleep Disorders	6
		Social Worker (MSW, ASW)	12
		Sports Medicine	2
		Substance Abuse Counselor	1
		Thoracic and Cardiovascular Surgery	2

		Thoracic Surgery	5
		Thoracic, Cardiovascular, Vascular Surge	3
	Muskogee Total		721
	New Orleans	Allergy	17
		Ambulatory Surgical Center	13
		Anesthesiology	104
		Audiology	13
		Bariatric Surgery	1
		Cardiovascular Disease	222
		Certified Reg. Nurse Anesthetist (CRNA)	87
		Chiropractor, Licensed	1
		Dermatology	31
		Dermatology - MOHS Surgery	1
		Endocrinologists	25
		Family Practice	4
		Freestanding Imaging Facility	7
		Gastroenterology	107
		General Surgery	103
		Geriatrics	6
		Gynecologic Oncology	3
		Gynecology (Osteopaths)	2
		Hematology	21
		Independent Laboratory	7
		Infectious Disease	21
		Internal Medicine	320
		Kidney Centers	13
		Long Term General Hospital	3
		Marriage and Family Counselor	21
		Mental Health Counselor	35
		Nephrology	37
		Neurological Surgery	17
		Neurology	39
		Neuro-Ophthalmology	1
		Neuroradiology	1
		Nuclear Medicine	4
		OB/GYN	112
		Occupational Therapy	5
		Oncology	50
		Ophthalmology	90
		Ophthalmology-Glaucoma Specialist	17

		Ophthalmology-Retina Specialist	19
		Optometrist	48
		Orthopedic Surgery	85
		Otology, Laryngology & Rhinology	23
		Pain Management	18
		Pathology	55
		Physical Medicine & Rehabilitation	15
		Physical Therapist	19
		Plastic Surgery	11
		Podiatric Surgery	1
		Podiatry	32
		Psychiatric	1
		Psychiatry	12
		Psychiatry, Neurology (Osteopaths Only)	1
		Psychologists	34
		Pulmonary and Critical Care	5
		Pulmonary Disease	54
		Radiation Oncology	13
		Radiology	180
		Rehabilitation	1
		Reproductive Endocrinology	2
		Rheumatology	27
		Short Term General Hospital	19
		Sleep Disorders	5
		Social Worker (MSW, ASW)	102
		Speech Pathologist/Speech Therapist	3
		Sports Medicine	4
		Thoracic Surgery	11
		Thoracic, Cardiovascular, Vascular Surge	9
		Urology	72
		Vascular Surgery	7
	New Orleans Total		2,449
	Oklahoma City	Allergy	28
		Ambulatory Surgical Center	4
		Anesthesiology	46
		Audiology	4
		Cardiovascular Disease	42
		Certified Reg. Nurse	38

		Anesthetist (CRNA)	
		Chiropractor, Licensed	8
		Craniomaxiallofacial Surgery	2
		Dermatology	9
		Endocrinologists	7
		Family Practice	9
		Freestanding Imaging Facility	9
		Gastroenterology	33
		General Surgery	35
		Geriatrics	9
		Gynecologic Oncology	1
		Gynecology Only	1
		Hand Surgery	1
		Hematology	3
		Independent Laboratory	53
		Infectious Disease	7
		Internal Medicine	107
		Internal Medicine, Hospital Only	1
		Interventional Cardiology	1
		Kidney Centers	4
		Long Term General Hospital	2
		Marriage and Family Counselor	7
		Mental Health Counselor	58
		Nephrology	14
		Neurological Surgery	4
		Neurology	16
		Neuroradiology	6
		Nuclear Medicine	7
		OB/GYN	52
		Occupational Therapy	8
		Oncology	48
		Ophthalmology	21
		Ophthalmology-Retina Specialist	2
		Optometrist	15
		Oral Pathology	2
		Orthopedic Surgery	23
		Otology, Laryngology & Rhinology	11
		Pain Management	11
		Pathology	18
		Physical Medicine & Rehabilitation	1

		Physical Therapist	322
		Plastic Surgery	4
		Podiatry	4
		Psychiatric	1
		Psychiatry	8
		Psychologists	27
		Pulmonary Disease	15
		Radiation Oncology	3
		Radiology	93
		Reproductive Endocrinology	1
		Rheumatology	1
		Short Term General Hospital	26
		Sleep Disorders	7
		Social Worker (MSW, ASW)	28
		Speech Pathologist/Speech Therapist	16
		Sports Medicine	3
		Thoracic and Cardiovascular Surgery	1
		Thoracic Surgery	6
		Thoracic, Cardiovascular, Vascular Surge	3
		Urology	6
		Vascular and Interventional Radiology	6
		Vascular Surgery	1
	Oklahoma City Total		1,370
	Shreveport	Allergy	11
		Ambulatory Surgical Center	6
		Anesthesiology	90
		Bariatric Surgery	1
		Cardiovascular Disease	44
		Certified Reg. Nurse Anesthetist (CRNA)	55
		Dermatology	11
		Endocrinologists	17
		Family Practice	30
		Freestanding Imaging Facility	13
		Gastroenterology	63
		General Practice	1
		General Surgery	82
		Geriatrics	2
		Gynecologic Oncology	3
		Gynecology (Osteopaths)	2

		Hematology	26
		Hyperbaric Medicine	1
		Independent Laboratory	8
		Infectious Disease	14
		Internal Medicine	221
		Interventional Cardiology	2
		Kidney Centers	6
		Long Term General Hospital	1
		Marriage and Family Counselor	22
		Mental Health Counselor	30
		Nephrology	80
		Neurological Surgery	13
		Neurology	23
		OB/GYN	70
		Occupational Medicine	2
		Oncology	46
		Ophthalmology	58
		Ophthalmology, Otology, Lary. & Rhin	11
		Ophthalmology-Retina Specialist	7
		Optometrist	8
		Orthopedic Surgery	61
		Otology, Laryngology & Rhinology	31
		Pain Management	9
		Pathology	56
		Physical Medicine & Rehabilitation	12
		Physical Therapist	13
		Plastic Surgery	5
		Podiatry	23
		Psychiatric	2
		Psychiatry	11
		Psychologists	14
		Pulmonary Disease	22
		Radiation Oncology	4
		Radiology	78
		Rehabilitation	1
		Reproductive Endocrinology	5
		Rheumatology	8
		Short Term General Hospital	30
		Sleep Disorders	1
		Social Worker (MSW, ASW)	12

		Thoracic and Cardiovascular Surgery	5
		Thoracic Surgery	12
		Thoracic, Cardiovascular, Vascular Surge	11
		Urology	25
		Vascular Surgery	3
		Wound Care	5
	Shreveport Total		1,539
16 Total			10,851
20	Boise	Ambulatory Surgical Center	5
		Audiology	14
		Certified Reg. Nurse Anesthetist (CRNA)	10
		Dermatology	1
		Endocrinologists	1
		Family Practice	1
		Freestanding Imaging Facility	1
		Gastroenterology	7
		General Practice	1
		General Surgery	15
		Independent Laboratory	2
		Internal Medicine	34
		Marriage and Family Counselor	10
		Mental Health Counselor	48
		Ophthalmology	21
		Ophthalmology-Retina Specialist	1
		Optometrist	30
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	1
		Physical Medicine & Rehabilitation	14
		Physical Therapist	26
		Podiatry	1
		Psychiatry	6
		Psychologists	12
		Radiology	22
		Short Term General Hospital	4
		Sleep Disorders	3
		Social Worker (MSW, ASW)	41

		Speech Pathologist/Speech Therapist	3
		Vascular Surgery	1
	Boise Total		337
	Portland	Acupuncture (Non-Physician)	1
		Allergy	2
		Ambulatory Surgical Center	5
		Anesthesiology	1
		Audiology	4
		C and P Audiology	1
		Cardiovascular Disease	52
		Certified Reg. Nurse Anesthetist (CRNA)	27
		Chiropractor, Licensed	1
		Dermatology	6
		Dermatology - MOHS Surgery	3
		Endocrinologists	3
		Freestanding Imaging Facility	5
		Gastroenterology	29
		General Surgery	32
		Gynecologic Oncology	1
		Independent Laboratory	9
		Infectious Disease	1
		Internal Medicine	65
		Marriage and Family Counselor	15
		Mental Health Counselor	49
		Nephrology	5
		Neurological Surgery	1
		Neurology	26
		OB/GYN	8
		Occupational Therapy	2
		Oncology	7
		Ophthalmology	37
		Optometrist	90
		Orthopedic Surgery	3
		Otology, Laryngology & Rhinology	15
		Pain Management	3
		Pathology	18
		Physical Medicine & Rehabilitation	49
		Physical Therapist	77
		Podiatry	12

		Psychiatry	3
		Psychologists	31
		Pulmonary Disease	21
		Radiology	67
		Rheumatology	4
		Short Term General Hospital	6
		Sleep Disorders	7
		Social Worker (MSW, ASW)	51
		Thoracic and Cardiovascular Surgery	3
		Thoracic Surgery	18
		Thoracic, Cardiovascular, Vascular Surge	8
		Urology	9
	Portland Total		893
	Puget Sound	Acupuncture (Non-Physician)	2
		Allergy	1
		Ambulatory Surgical Center	9
		Anesthesiology	50
		Audiology	33
		Cardiovascular Disease	108
		Certified Reg. Nurse Anesthetist (CRNA)	70
		Dermatology	20
		Dermatology - MOHS Surgery	5
		Diagnostic Radiology	10
		Endocrinologists	3
		Family Practice	7
		Freestanding Imaging Facility	6
		Gastroenterology	44
		General Surgery	129
		General, Thoracic and Vascular Surgery	2
		Geriatrics	5
		Gynecology (Osteopaths)	1
		Hand Surgery	1
		Hematology	2
		Independent Laboratory	43
		Infectious Disease	3
		Internal Medicine	593
		Interventional Cardiology	5
		Marriage and Family Counselor	25
		Mental Health Counselor	70

		Nephrology	26
		Neurological Surgery	43
		Neurology	54
		Neuroradiology	15
		Nuclear Medicine	8
		OB/GYN	105
		Occupational Medicine	3
		Occupational Therapy	18
		Oncology	28
		Ophthalmology	62
		Optometrist	162
		Orthopedic Surgery	62
		Otology, Laryngology & Rhinology	34
		Pain Management	12
		Pathology	16
		Physical Medicine & Rehabilitation	19
		Physical Therapist	108
		Plastic Surgery	2
		Podiatry	45
		Portable X-Ray or Lithotripter	1
		Psychiatry	29
		Psychologists	31
		Pulmonary Disease	26
		Radiation Oncology	5
		Radiology	505
		Rheumatology	14
		Short Term General Hospital	21
		Sleep Disorders	16
		Social Worker (MSW, ASW)	61
		Speech Pathologist/Speech Therapist	8
		Sports Medicine	1
		Substance Abuse Counselor	1
		Thoracic and Cardiovascular Surgery	7
		Thoracic and Vascular Surgery	1
		Thoracic Surgery	16
		Thoracic, Cardiovascular, Vascular Surge	1
		Urology	22
		Vascular Surgery	18
	Puget Sound Total		2,853

	Roseburg	Acupuncture (Non-Physician)	1
		Ambulatory Surgical Center	8
		Audiology	3
		Cardiovascular Disease	13
		Certified Reg. Nurse Anesthetist (CRNA)	2
		Dermatology	1
		Endocrinologists	2
		Family Practice	22
		Freestanding Imaging Facility	3
		Gastroenterology	1
		General Practice	2
		General Surgery	16
		Geriatrics	8
		Independent Laboratory	8
		Infectious Disease	3
		Internal Medicine	87
		Marriage and Family Counselor	6
		Mental Health Counselor	7
		Nephrology	2
		Neurological Surgery	2
		Neurology	8
		OB/GYN	7
		Occupational Therapy	3
		Oncology	36
		Ophthalmology	47
		Optometrist	9
		Orthopedic Surgery	6
		Otology, Laryngology & Rhinology	5
		Physical Medicine & Rehabilitation	2
		Physical Therapist	28
		Podiatry	2
		Psychologists	9
		Pulmonary Disease	1
		Radiation Oncology	2
		Radiology	231
		Short Term General Hospital	5
		Sleep Disorders	5
		Social Worker (MSW, ASW)	16
		Thoracic and Cardiovascular Surgery	3
		Thoracic Surgery	1

		Urology	1
		Vascular and Interventional Radiology	1
		Vascular Surgery	1
	Roseburg Total		626
	Spokane	Acupuncture (Non-Physician)	1
		Allergy	1
		Ambulatory Surgical Center	2
		Anesthesiology	33
		Audiology	5
		Cardiovascular Disease	15
		Certified Reg. Nurse Anesthetist (CRNA)	44
		Dermatology	3
		Endocrinologists	7
		Freestanding Imaging Facility	8
		General Practice	1
		General Surgery	10
		Independent Laboratory	4
		Internal Medicine	22
		Marriage and Family Counselor	5
		Mental Health Counselor	37
		Nephrology	7
		Neurological Surgery	2
		Neurology	5
		OB/GYN	12
		Occupational Therapy	3
		Oncology	8
		Ophthalmology	16
		Optometrist	43
		Orthopedic Surgery	6
		Otology, Laryngology & Rhinology	6
		Pathology	8
		Physical Medicine & Rehabilitation	3
		Physical Therapist	34
		Podiatry	1
		Psychologists	7
		Pulmonary Disease	7
		Radiation Oncology	3
		Radiology	291
		Reproductive Endocrinology	1

		Short Term General Hospital	5
		Sleep Disorders	2
		Social Worker (MSW, ASW)	13
		Speech Pathologist/Speech Therapist	3
		Substance Abuse Counselor	1
		Thoracic and Cardiovascular Surgery	2
		Thoracic Surgery	1
		Urology	2
	Spokane Total		690
	Walla Walla	Allergy	1
		Ambulatory Surgical Center	6
		Anesthesiology	7
		Audiology	18
		Cardiovascular Disease	9
		Certified Reg. Nurse Anesthetist (CRNA)	32
		Dermatology	2
		Endocrinologists	2
		Freestanding Imaging Facility	4
		Gastroenterology	3
		General Surgery	4
		Geriatrics	1
		Independent Laboratory	1
		Infectious Disease	1
		Internal Medicine	45
		Kidney Centers	1
		Marriage and Family Counselor	2
		Mental Health Counselor	22
		Nephrology	5
		Neurological Surgery	7
		Neurology	4
		OB/GYN	16
		Occupational Medicine	2
		Occupational Therapy	1
		Ophthalmology	31
		Ophthalmology, Otology, Lary. & Rhin	1
		Optometrist	83
		Orthopedic Surgery	13
		Otology, Laryngology & Rhinology	2

		Physical Medicine & Rehabilitation	4
		Physical Therapist	45
		Plastic Surgery	1
		Podiatry	8
		Psychologists	3
		Pulmonary Disease	3
		Radiology	53
		Short Term General Hospital	9
		Sleep Disorders	3
		Social Worker (MSW, ASW)	19
		Speech Pathologist/Speech Therapist	3
		Thoracic and Cardiovascular Surgery	2
		Thoracic Surgery	4
		Urology	1
	Walla Walla Total		484
	White City	Ambulatory Surgical Center	1
		Audiology	8
		Freestanding Imaging Facility	1
		Marriage and Family Counselor	7
		Mental Health Counselor	4
		Optometrist	5
		Physical Therapist	4
		Podiatry	1
		Psychologists	2
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	6
	White City Total		40
20 Total			5,923
23	Black Hills	Allergy	1
		Anesthesiology	2
		Audiology	1
		Cardiovascular Disease	10
		Certified Reg. Nurse Anesthetist (CRNA)	17
		Chiropractor, Licensed	19
		Dermatology	1
		Endocrinologists	1
		Family Practice	1

		Freestanding Imaging Facility	1
		General Surgery	20
		Geriatrics	1
		Independent Laboratory	1
		Internal Medicine	25
		Marriage and Family Counselor	2
		Mental Health Counselor	5
		Nephrology	3
		Neurological Surgery	3
		Neurology	1
		OB/GYN	3
		Occupational Therapy	1
		Optometrist	4
		Orthopedic Surgery	3
		Otology, Laryngology & Rhinology	5
		Physical Therapist	20
		Podiatry	5
		Psychologists	4
		Pulmonary Disease	4
		Radiology	12
		Rheumatology	1
		Short Term General Hospital	5
		Social Worker (MSW, ASW)	2
		Urology	5
	Black Hills Total		189
	Central Iowa	Allergy	4
		Anesthesiology	1
		Audiology	2
		Cardiovascular Disease	1
		Chiropractor, Licensed	1
		Dermatology	1
		Endocrinologists	10
		Family Practice	30
		Freestanding Imaging Facility	1
		Gastroenterology	6
		General Surgery	13
		Geriatrics	5
		Independent Laboratory	2
		Internal Medicine	36
		Marriage and Family Counselor	4
		Mental Health Counselor	14

		Nephrology	2
		Neurological Surgery	3
		Neurology	8
		Nuclear Medicine	5
		OB/GYN	3
		Occupational Therapy	8
		Oncology	1
		Ophthalmology	11
		Optometrist	6
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	4
		Pain Management	1
		Pathology	1
		Physical Medicine & Rehabilitation	2
		Physical Therapist	31
		Plastic Surgery	2
		Podiatry	13
		Psychologists	9
		Radiation Oncology	1
		Radiology	4
		Rehabilitation	4
		Rheumatology	11
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	26
		Speech Pathologist/Speech Therapist	3
		Sports Medicine	1
		Urology	1
	Central Iowa Total		294
	Fargo	Allergy	2
		Ambulatory Surgical Center	3
		Anesthesiology	7
		Audiology	12
		Cardiovascular Disease	4
		Certified Reg. Nurse Anesthetist (CRNA)	7
		Chiropractor, Licensed	14
		Dermatology	1
		Dermatology - MOHS Surgery	1
		Family Practice	17
		Freestanding Imaging Facility	3
		Gastroenterology	4

		General Surgery	6
		Hematology	3
		Infectious Disease	1
		Internal Medicine	23
		Internal Medicine, Hospital Only	1
		Kidney Centers	2
		Marriage and Family Counselor	3
		Mental Health Counselor	8
		Nephrology	1
		Neurological Surgery	2
		OB/GYN	6
		Occupational Therapy	14
		Oncology	4
		Ophthalmology	10
		Ophthalmology-Retina Specialist	2
		Optometrist	46
		Orthopedic Surgery	17
		Otology, Laryngology & Rhinology	5
		Pain Management	1
		Pathology	5
		Physical Medicine & Rehabilitation	3
		Physical Therapist	29
		Plastic Surgery	4
		Podiatry	3
		Psychiatry	4
		Psychologists	4
		Pulmonary Disease	4
		Radiology	14
		Rheumatology	1
		Short Term General Hospital	2
		Sleep Disorders	3
		Social Worker (MSW, ASW)	11
		Speech Pathologist/Speech Therapist	21
		Thoracic, Cardiovascular, Vascular Surge	1
		Urology	3
	Fargo Total		342
	Iowa City	Ambulatory Surgical Center	3

		Anesthesiology	4
		Certified Reg. Nurse Anesthetist (CRNA)	6
		Chiropractor, Licensed	2
		Dermatology	1
		Dermatology - MOHS Surgery	1
		Freestanding Imaging Facility	2
		Gastroenterology	7
		General Surgery	10
		Independent Laboratory	10
		Internal Medicine	3
		Kidney Centers	1
		Marriage and Family Counselor	5
		Mental Health Counselor	24
		Nuclear Medicine	1
		OB/GYN	1
		Occupational Therapy	7
		Ophthalmology	6
		Optometrist	2
		Pain Management	2
		Physical Medicine & Rehabilitation	2
		Physical Therapist	119
		Podiatry	3
		Psychiatric	1
		Psychiatry	9
		Psychologists	17
		Pulmonary Disease	5
		Radiation Oncology	2
		Radiology	1
		Rehabilitation	3
		Short Term General Hospital	10
		Social Worker (MSW, ASW)	37
		Speech Pathologist/Speech Therapist	4
		Urology	1
	Iowa City Total		312
	Minneapolis	Allergy	1
		Ambulatory Surgical Center	5
		Anesthesiology	30
		Audiology	135
		C and P Audiology	21
		Cardiovascular Disease	137

		Dermatology	1
		Endocrinologists	2
		Freestanding Imaging Facility	17
		Gastroenterology	65
		General Surgery	25
		Hematology	2
		Independent Laboratory	9
		Infectious Disease	1
		Internal Medicine	432
		Long Term General Hospital	2
		Marriage and Family Counselor	50
		Mental Health Counselor	17
		Nephrology	19
		Neurological Surgery	13
		Neurology	65
		OB/GYN	6
		Occupational Therapy	19
		Oncology	46
		Ophthalmology	27
		Optometrist	6
		Orthopedic Surgery	51
		Otology, Laryngology & Rhinology	20
		Pain Management	59
		Pathology	34
		Physical Medicine & Rehabilitation	14
		Physical Therapist	133
		Plastic Surgery	1
		Podiatry	28
		Psychiatry	8
		Psychologists	97
		Pulmonary Disease	12
		Radiation Oncology	6
		Radiology	421
		Rehabilitation	3
		Rheumatology	5
		Short Term General Hospital	3
		Sleep Disorders	4
		Social Worker (MSW, ASW)	95
		Speech Pathologist/Speech Therapist	1
		Thoracic and Cardiovascular Surgery	3

		Thoracic Surgery	7
		Urology	2
		Vascular Surgery	3
	Minneapolis Total		2,163
	NW Iowa	Ambulatory Surgical Center	6
		Anesthesiology	11
		Cardiovascular Disease	28
		Certified Reg. Nurse Anesthetist (CRNA)	16
		Chiropractor, Licensed	189
		Dermatology	10
		Family Practice	10
		Freestanding Imaging Facility	1
		Gastroenterology	12
		General Surgery	19
		General, Thoracic and Vascular Surgery	2
		Hematology	3
		Independent Laboratory	5
		Infectious Disease	1
		Internal Medicine	31
		Kidney Centers	6
		Mental Health Counselor	54
		Nephrology	7
		Neurological Surgery	2
		Neurology	5
		OB/GYN	8
		Occupational Therapy	9
		Oncology	4
		Ophthalmology	7
		Ophthalmology, Otology, Lary. & Rhin	1
		Optometrist	7
		Orthopedic Surgery	8
		Otology, Laryngology & Rhinology	3
		Pain Management	2
		Pathology	18
		Pathology/Clinical Path (Osteo Only)	1
		Physical Medicine & Rehabilitation	1
		Physical Therapist	34
		Plastic Surgery	1

		Podiatry	2
		Psychiatry	1
		Psychologists	7
		Pulmonary Disease	10
		Radiation Oncology	1
		Radiology	19
		Rheumatology	2
		Short Term General Hospital	9
		Sleep Disorders	4
		Social Worker (MSW, ASW)	15
		Speech Pathologist/Speech Therapist	6
		Thoracic and Cardiovascular Surgery	1
		Thoracic Surgery	3
		Urology	6
		Vascular Surgery	2
	NW Iowa Total		610
	Omaha	Allergy	1
		Ambulatory Surgical Center	4
		Anesthesiology	23
		Bariatric Surgery	5
		Cardiovascular Disease	11
		Certified Reg. Nurse Anesthetist (CRNA)	2
		Chiropractor, Licensed	135
		Dermatology	35
		Dermatology - MOHS Surgery	2
		Endocrinologists	3
		Gastroenterology	35
		General Surgery	39
		Geriatrics	1
		Hand Surgery	1
		Hematology	3
		Independent Laboratory	1
		Infectious Disease	10
		Internal Medicine	70
		Mental Health Counselor	74
		Nephrology	10
		Neurology	11
		OB/GYN	25
		Obstetric Surgery	1
		Oncology	9
		Ophthalmology	10

		Optometrist	6
		Orthopedic Surgery	53
		Otolaryngology - head and neck surgery	1
		Otology, Laryngology & Rhinology	4
		Pain Management	2
		Pathology	17
		Physical Medicine & Rehabilitation	4
		Physical Therapist	29
		Plastic Surgery	1
		Podiatry	15
		Psychiatry	1
		Psychologists	15
		Pulmonary Disease	2
		Radiation Oncology	9
		Radiology	39
		Reproductive Endocrinology	2
		Rheumatology	3
		Short Term General Hospital	3
		Social Worker (MSW, ASW)	17
		Thoracic and Cardiovascular Surgery	3
		Thoracic Surgery	3
		Vascular Surgery	5
	Omaha Total		755
	Sioux Falls	Ambulatory Surgical Center	1
		Anesthesiology	20
		Cardiovascular Disease	5
		Chiropractor, Licensed	6
		Dermatology	4
		Endocrinologists	4
		Family Practice	39
		Gastroenterology	6
		General Practice	2
		General Surgery	41
		Geriatrics	1
		Hematology	3
		Infectious Disease	2
		Internal Medicine	63
		Internal Medicine, Hospital Only	1
		Marriage and Family	7

		Counselor	
		Mental Health Counselor	22
		Nephrology	12
		Neurological Surgery	3
		Neurology	1
		Nuclear Medicine	1
		OB/GYN	41
		Occupational Medicine	1
		Oncology	7
		Ophthalmology	1
		Optometrist	1
		Orthopedic Surgery	12
		Otology, Laryngology & Rhinology	3
		Pain Management	1
		Physical Medicine & Rehabilitation	10
		Physical Therapist	17
		Podiatry	9
		Psychologists	12
		Pulmonary Disease	8
		Radiation Oncology	1
		Radiology	7
		Rheumatology	1
		Short Term General Hospital	9
		Social Worker (MSW, ASW)	14
		Sports Medicine	1
		Substance Abuse Counselor	1
		Urology	4
	Sioux Falls Total		405
	St. Cloud	Ambulatory Surgical Center	3
		Anesthesiology	16
		Audiology	18
		Cardiovascular Disease	25
		Certified Reg. Nurse Anesthetist (CRNA)	2
		Dermatology	7
		Endocrinologists	5
		Freestanding Imaging Facility	3
		Gastroenterology	10
		General Surgery	11
		Hematology	7
		Infectious Disease	2
		Internal Medicine	65

		Marriage and Family Counselor	9
		Nephrology	13
		Neurological Surgery	9
		Neurology	8
		OB/GYN	16
		Occupational Therapy	5
		Oncology	12
		Ophthalmology	5
		Optometrist	2
		Orthopedic Surgery	7
		Otology, Laryngology & Rhinology	7
		Pain Management	19
		Physical Therapist	32
		Podiatry	2
		Psychiatry	4
		Psychologists	23
		Pulmonary and Critical Care	1
		Pulmonary Disease	7
		Radiology	25
		Rheumatology	6
		Short Term General Hospital	2
		Sleep Disorders	1
		Social Worker (MSW, ASW)	18
		Thoracic Surgery	1
		Urology	1
	St. Cloud Total		409
23 Total			**5,479**
Humana Veterans Provider Network Grand Total			**30,284**

Question 25. Does VA consider Project HERO a success? If so, does VA anticipate expanding the project, or similar projects?

Response. Project HERO has had many successes and challenges, but VA cannot expand the current contract. As a demonstration pilot, it has been a vehicle to gather invaluable information for VA to better understand methods to utilize contracted

networks to meet its needs when purchasing needed care outside VA medical centers. The Project HERO Program Management Office (PMO) gathers, applies and shares these lessons learned in this program and other purchased care contracts. VA does anticipate a need to continue purchasing health care services in the community at some level. Similar projects will be planned to improve purchasing capability, impose quality standards, and leverage pricing where possible.

Question 26. How many Project HERO providers work in highly rural areas?

Response. (See Attachments 3 with detailed list of Project HERO providers who work in rural areas and Attachment 4 with Project HERO Delta Federal Services in rural areas, which follow).

ATTACHMENT 3 FOR QUESTION 26

Humana Veterans Provider Network
Rural* Locations
10/20/09

VISN	Catchment	Specialty	Rural Provider Network Total
8	Bay Pines	Dermatology	1
		Family Practice	16
		Freestanding Imaging Facility	1
		Independent Laboratory	2
		Internal Medicine	26
		Neurology	2
		OB/GYN	2
		Ophthalmology	1
		Optometrist	10
		Orthopedic Surgery	1
		Physical Therapist	4
		Radiology	3
		Short Term General Hospital	1
	Bay Pines Total		70
	North Florida/South Georgia	Allergy	1
		Cardiovascular Disease	6
		Dermatology	2
		Family Practice	10
		Independent Laboratory	2
		Internal Medicine	17
		Marriage and Family Counselor	6
		Mental Health Counselor	14
		Nuclear Medicine	1
		Oncology	2
		Ophthalmology	1
		Pain Management	3
		Physical Therapist	1
		Podiatry	5
		Psychiatry	3
		Psychologists	7
		Pulmonary Disease	1
		Radiation Oncology	18

		Radiology	52
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	14
	North Florida/South Georgia Total		167
	Orlando	Audiology	3
		Dermatology	9
		Freestanding Imaging Facility	3
		General Practice	2
		Internal Medicine	8
		Marriage and Family Counselor	1
		Mental Health Counselor	5
		Neurology	5
		Occupational Therapy	2
		Physical Medicine & Rehabilitation	2
		Physical Therapist	10
		Podiatry	2
		Psychologists	1
		Radiology	25
		Social Worker (MSW, ASW)	1
		Urology	4
	Orlando Total		83
	Tampa	Allergy	1
		Ambulatory Surgical Center	3
		Cardiovascular Disease	16
		Dermatology	21
		Dermatology - MOHS Surgery	8
		Family Practice	11
		Freestanding Imaging Facility	3
		Gastroenterology	4
		General Practice	1
		General Surgery	5
		Internal Medicine	11
		Interventional Cardiology	1
		Nephrology	14
		Neurology	4
		OB/GYN	3
		Occupational Therapy	32
		Ophthalmology	12
		Optometrist	21
		Otology, Laryngology &	2

		Rhinology	
		Physical Therapist	99
		Plastic Surgery	1
		Podiatry	2
		Radiology	20
		Rehabilitation	1
		Rheumatology	4
		Short Term General Hospital	5
		Social Worker (MSW, ASW)	1
		Thoracic and Cardiovascular Surgery	1
		Thoracic Surgery	1
		Urology	2
	Tampa Total		310
	West Palm Beach	Family Practice	9
		General Practice	2
		Internal Medicine	6
	West Palm Beach Total		17
8 Total			**647**
16	Alexandria	Cardiovascular Disease	11
		Chiropractor, Licensed	2
		Freestanding Imaging Facility	1
		General Practice	1
		General Surgery	1
		Hematology	2
		Independent Laboratory	1
		Internal Medicine	3
		Kidney Centers	3
		Marriage and Family Counselor	8
		Mental Health Counselor	17
		Nephrology	10
		Occupational Therapy	1
		Oncology	3
		Optometrist	6
		Otology, Laryngology & Rhinology	1
		Physical Therapist	5
		Podiatry	2
		Psychiatric	2
		Psychiatry	3
		Psychologists	4
		Pulmonary Disease	1

		Radiology	2
		Short Term General Hospital	5
		Sleep Disorders	2
		Social Worker (MSW, ASW)	9
		Speech Pathologist/Speech Therapist	3
		Vascular Surgery	1
	Alexandria Total		110
	Fayetteville	Allergy	1
		Ambulatory Surgical Center	2
		Anesthesiology	3
		Cardiovascular Disease	12
		Certified Reg. Nurse Anesthetist (CRNA)	3
		Chiropractor, Licensed	9
		Dermatology	2
		Family Practice	16
		Freestanding Imaging Facility	3
		Gastroenterology	3
		General Practice	1
		General Surgery	17
		Geriatrics	3
		Hand Surgery	1
		Independent Laboratory	3
		Internal Medicine	4
		Kidney Centers	2
		Mental Health Counselor	19
		Nephrology	1
		OB/GYN	2
		Occupational Therapy	2
		Oncology	1
		Ophthalmology	3
		Optometrist	21
		Orthopedic Surgery	6
		Otology, Laryngology & Rhinology	3
		Physical Medicine & Rehabilitation	7
		Physical Therapist	6
		Plastic Surgery	1
		Podiatry	8
		Psychiatry	7
		Psychologists	22
		Pulmonary Disease	8

		Radiology	23
		Short Term General Hospital	4
		Social Worker (MSW, ASW)	3
		Thoracic and Vascular Surgery	4
		Thoracic, Cardiovascular, Vascular Surge	4
		Urology	4
	Fayetteville Total		244
	Gulf Coast (Biloxi)	Anesthesiology	4
		Cardiovascular Disease	3
		Family Practice	3
		Gastroenterology	1
		General Surgery	1
		Independent Laboratory	2
		Internal Medicine	4
		Kidney Centers	1
		Marriage and Family Counselor	1
		Mental Health Counselor	7
		Occupational Therapy	2
		Oncology	3
		Ophthalmology	5
		Ophthalmology-Retina Specialist	3
		Physical Therapist	11
		Psychiatry	3
		Psychologists	1
		Radiation Oncology	1
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	3
	Gulf Coast (Biloxi) Total		60
	Houston	Independent Laboratory	7
		Kidney Centers	1
		Marriage and Family Counselor	2
		Mental Health Counselor	12
		Ophthalmology	2
		Optometrist	1
		Psychologists	7
		Short Term General Hospital	3
		Social Worker (MSW, ASW)	5
		Urology	2

	Houston Total		42
	Jackson	Cardiovascular Disease	2
		Family Practice	29
		Gastroenterology	2
		General Surgery	2
		Independent Laboratory	11
		Internal Medicine	7
		Mental Health Counselor	1
		Ophthalmology	1
		Physical Therapist	2
		Radiology	3
		Short Term General Hospital	3
		Social Worker (MSW, ASW)	2
		Urology	2
	Jackson Total		67
	Little Rock	Audiology	2
		Chiropractor, Licensed	1
		Dermatology	1
		Family Practice	7
		Gastroenterology	1
		General Practice	2
		General Surgery	1
		Internal Medicine	13
		Kidney Centers	4
		Marriage and Family Counselor	3
		Mental Health Counselor	44
		OB/GYN	1
		Occupational Therapy	1
		Ophthalmology	5
		Physical Therapist	18
		Podiatry	4
		Psychiatry	16
		Psychologists	15
		Pulmonary Disease	1
		Short Term General Hospital	4
		Social Worker (MSW, ASW)	41
	Little Rock Total		185
	Muskogee	Anesthesiology	1
		Cardiovascular Disease	8
		Certified Reg. Nurse Anesthetist (CRNA)	4

		Family Practice	14
		General Surgery	5
		Internal Medicine	12
		Kidney Centers	1
		Marriage and Family Counselor	1
		Nephrology	4
		Nuclear Medicine	1
		OB/GYN	6
		Ophthalmology	5
		Optometrist	7
		Orthopedic Surgery	2
		Otology, Laryngology & Rhinology	3
		Pain Management	1
		Physical Therapist	64
		Podiatry	1
		Psychiatry	2
		Psychologists	1
		Radiology	1
		Short Term General Hospital	6
		Social Worker (MSW, ASW)	1
	Muskogee Total		151
	New Orleans	Cardiovascular Disease	10
		Family Practice	4
		Gastroenterology	2
		General Surgery	3
		Geriatrics	1
		Independent Laboratory	1
		Internal Medicine	6
		Kidney Centers	3
		Marriage and Family Counselor	21
		Mental Health Counselor	34
		Neurology	1
		Ophthalmology	4
		Ophthalmology-Glaucoma Specialist	2
		Optometrist	4
		Orthopedic Surgery	5
		Pathology	2
		Physical Therapist	3
		Psychiatric	1
		Psychiatry	12

		Psychologists	34
		Radiology	2
		Short Term General Hospital	2
		Social Worker (MSW, ASW)	102
		Speech Pathologist/Speech Therapist	1
	New Orleans Total		260
	Oklahoma City	Certified Reg. Nurse Anesthetist (CRNA)	1
		Chiropractor, Licensed	2
		Family Practice	9
		Freestanding Imaging Facility	1
		General Surgery	3
		Independent Laboratory	12
		Internal Medicine	4
		Mental Health Counselor	9
		OB/GYN	3
		Occupational Therapy	1
		Oncology	2
		Ophthalmology	6
		Optometrist	8
		Orthopedic Surgery	2
		Physical Therapist	33
		Psychologists	2
		Pulmonary Disease	1
		Radiology	2
		Short Term General Hospital	11
		Sleep Disorders	1
	Oklahoma City Total		113
	Shreveport	Cardiovascular Disease	1
		Endocrinologists	2
		Family Practice	30
		General Practice	1
		General Surgery	1
		Geriatrics	1
		Hyperbaric Medicine	1
		Internal Medicine	13
		Mental Health Counselor	3
		Nephrology	40
		Optometrist	1
		Physical Therapist	1
		Podiatry	1
		Psychiatry	2

		Psychologists	6
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	1
		Urology	3
		Wound Care	1
	Shreveport Total		110
16 Total			**1,342**
20	Boise	Family Practice	1
		General Practice	1
		Internal Medicine	1
		Marriage and Family Counselor	10
		Mental Health Counselor	48
		Ophthalmology	1
		Physical Medicine & Rehabilitation	14
		Physical Therapist	3
		Podiatry	1
		Psychiatry	5
		Psychologists	12
		Social Worker (MSW, ASW)	41
	Boise Total		138
	Portland	Cardiovascular Disease	6
		Freestanding Imaging Facility	1
		Independent Laboratory	3
		Internal Medicine	1
		Marriage and Family Counselor	1
		Mental Health Counselor	12
		Ophthalmology	3
		Optometrist	8
		Physical Medicine & Rehabilitation	14
		Physical Therapist	2
		Short Term General Hospital	1
		Sleep Disorders	1
		Social Worker (MSW, ASW)	2
	Portland Total		55
	Puget Sound	Ambulatory Surgical Center	1
		Audiology	1
		Cardiovascular Disease	1
		Certified Reg. Nurse	12

		Anesthetist (CRNA)	
		Family Practice	7
		Independent Laboratory	5
		Internal Medicine	3
		Marriage and Family Counselor	3
		Mental Health Counselor	19
		OB/GYN	2
		Occupational Medicine	1
		Occupational Therapy	4
		Ophthalmology	14
		Optometrist	26
		Physical Therapist	11
		Psychologists	2
		Radiology	9
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	7
		Substance Abuse Counselor	1
	Puget Sound Total		130
	Roseburg	Ambulatory Surgical Center	3
		Endocrinologists	1
		Family Practice	22
		Freestanding Imaging Facility	2
		General Practice	2
		General Surgery	1
		Geriatrics	2
		Independent Laboratory	1
		Internal Medicine	20
		Marriage and Family Counselor	3
		Mental Health Counselor	3
		Nephrology	1
		OB/GYN	4
		Occupational Therapy	2
		Oncology	10
		Ophthalmology	20
		Optometrist	2
		Physical Medicine & Rehabilitation	1
		Physical Therapist	17
		Podiatry	1
		Psychologists	3
		Radiology	46
		Social Worker (MSW, ASW)	9

		Vascular and Interventional Radiology	1
	Roseburg Total		177
	Spokane	Anesthesiology	1
		Cardiovascular Disease	1
		General Practice	1
		General Surgery	2
		Independent Laboratory	1
		Internal Medicine	2
		Mental Health Counselor	7
		Ophthalmology	2
		Optometrist	8
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	1
		Physical Therapist	4
		Podiatry	1
		Psychologists	3
		Radiology	4
		Social Worker (MSW, ASW)	6
		Urology	1
	Spokane Total		46
	Walla Walla	Audiology	5
		General Surgery	1
		Kidney Centers	1
		Marriage and Family Counselor	2
		Mental Health Counselor	22
		Neurology	1
		Optometrist	1
		Physical Therapist	9
		Psychologists	3
		Radiology	11
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	19
	Walla Walla Total		76
	White City	Marriage and Family Counselor	7
		Mental Health Counselor	4
		Psychologists	2
		Social Worker (MSW, ASW)	6
	White City Total		19

20 Total			**641**
23	Black Hills	Certified Reg. Nurse Anesthetist (CRNA)	2
		Chiropractor, Licensed	10
		Family Practice	1
		General Surgery	3
		Geriatrics	1
		Internal Medicine	1
		Marriage and Family Counselor	2
		Mental Health Counselor	2
		Optometrist	1
		Orthopedic Surgery	1
		Otology, Laryngology & Rhinology	1
		Podiatry	2
		Psychologists	1
		Short Term General Hospital	4
		Urology	4
	Black Hills Total		36
	Central Iowa	Allergy	2
		Chiropractor, Licensed	1
		Family Practice	30
		General Surgery	3
		Internal Medicine	2
		Nuclear Medicine	2
		OB/GYN	1
		Occupational Therapy	1
		Ophthalmology	2
		Pathology	1
		Physical Therapist	7
		Podiatry	4
		Radiology	2
		Rehabilitation	1
		Social Worker (MSW, ASW)	10
	Central Iowa Total		69
	Fargo	Audiology	2
		Chiropractor, Licensed	2
		Family Practice	17
		Freestanding Imaging Facility	1
		Internal Medicine	5
		Marriage and Family	3

		Counselor	
		Mental Health Counselor	1
		Occupational Therapy	6
		Optometrist	32
		Orthopedic Surgery	1
		Physical Therapist	3
		Psychiatry	3
		Psychologists	2
		Radiology	2
		Social Worker (MSW, ASW)	9
		Speech Pathologist/Speech Therapist	1
		Urology	1
	Fargo Total		91
	Iowa City	Independent Laboratory	1
		Marriage and Family Counselor	2
		Mental Health Counselor	13
		Occupational Therapy	1
		Optometrist	1
		Physical Therapist	61
		Podiatry	2
		Psychiatry	4
		Psychologists	5
		Rehabilitation	2
		Social Worker (MSW, ASW)	11
	Iowa City Total		103
	Minneapolis	Audiology	59
		Independent Laboratory	2
		Marriage and Family Counselor	2
		Mental Health Counselor	3
		Ophthalmology	2
		Optometrist	2
		Orthopedic Surgery	2
		Physical Therapist	3
		Psychiatry	2
		Psychologists	21
		Social Worker (MSW, ASW)	25
	Minneapolis Total		123
	NW Iowa	Anesthesiology	1
		Cardiovascular Disease	19

		Certified Reg. Nurse Anesthetist (CRNA)	1
		Chiropractor, Licensed	70
		Family Practice	10
		General Surgery	3
		Independent Laboratory	2
		Internal Medicine	8
		Kidney Centers	2
		Mental Health Counselor	54
		Oncology	1
		Optometrist	3
		Orthopedic Surgery	2
		Physical Therapist	3
		Psychiatry	1
		Psychologists	7
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	15
	NW Iowa Total		203
	Omaha	Chiropractor, Licensed	7
		Gastroenterology	1
		Mental Health Counselor	1
		Oncology	1
		Optometrist	1
		Physical Therapist	3
		Podiatry	2
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	1
	Omaha Total		18
	Sioux Falls	Cardiovascular Disease	1
		Chiropractor, Licensed	6
		Family Practice	39
		General Practice	2
		General Surgery	31
		Geriatrics	1
		Internal Medicine	15
		Mental Health Counselor	7
		Nephrology	1
		OB/GYN	9
		Oncology	3
		Optometrist	1
		Orthopedic Surgery	8
		Otology, Laryngology & Rhinology	1

		Physical Medicine & Rehabilitation	6
		Physical Therapist	5
		Podiatry	3
		Psychologists	11
		Pulmonary Disease	1
		Radiation Oncology	1
		Radiology	5
		Short Term General Hospital	2
		Social Worker (MSW, ASW)	10
		Substance Abuse Counselor	1
		Urology	2
	Sioux Falls Total		172
	St. Cloud	Audiology	4
		Dermatology	1
		Marriage and Family Counselor	9
		Nephrology	3
		Occupational Therapy	5
		Ophthalmology	1
		Physical Therapist	22
		Psychiatry	4
		Psychologists	23
		Pulmonary Disease	1
		Short Term General Hospital	1
		Social Worker (MSW, ASW)	18
	St. Cloud Total		92
23 Total			907
Humana Veterans Rural Provider Network			**3,537**

*Providers included based on CMS datasets:
Physician Scarcity Areas - Primary Care
Physician Scarcity Areas - Specialty Care
Health Professional Shortage Areas - Mental Health

ATTACHMENT 4 FOR QUESTION 26

Delta Dental Insurance Company
Project HERO Dental Program
Credentialed Providers In Rural Areas
As of: October 16, 2009

Spec	Specialty	Count
000	General Practioner	2,763
010	Oral Surgeon	341
015	Endodontist	99
020	Orthodontist	54
030	Pediatric Dentist	0
040	Periodontist	79
050	Prosthodontist	16
	Total	**3,352**

Note:
Rural is defined as any zip code with fewer than 1,000 persons per square mile

Question 27. How would VA improve Project HERO if VA decided to expand it or create similar projects in other VISNs?

Response. While VA cannot expand the existing Project HERO pilot, if we were to create similar contracts in other VISNs, we have collected many lessons learned that would be applied to future purchased care contracts:

(a) Include broader and more in-depth stakeholder research and analysis through facilitated focus group sessions, requirements sessions, and improved bi-directional communications.

(b) Create contracts that are more adaptable to changing VA needs and regulations.

(c) Improve expected clinical quality standards and methods for capturing clinical quality information and measures.

(d) Establish care categories and definitions per industry, Centers for Medicare & Medicaid Services, and American Medical Association definitions.

(e) Consider making contract use mandatory as the first care purchasing option and if the contracted network cannot meet the need, defer to other purchased care methods.

(f) Establish health care pricing and payment methodologies that better reflect commercial market payment processes and rates.

(g) Include travel time and distance standards for purchased care, based on urban, rural, and highly rural situations.

(h) Create an environment that encourages and promotes physician-to-physician communication between the VA and community providers.

(i) Increase the use of VA's Computerized Patient Record System so VA and community providers have access to the same patient medical documentation, enhancing their ability to optimize Veteran care services.

(j) Implement a provider relations program to improve understanding and communication between community and VA providers

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 survey to begin an additional independent evaluation of the pilot. Both the prior evaluation 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.

Question 28. Are there widespread delays in the process to relocate existing CBOCs? For example, I have been told that the relocation of the Raton Community-Based Outpatient Clinic (CBOC) in New Mexico has been especially delayed.

Response. There have indeed been delays in obtaining leased community based outpatient clinics (CBOC) in New Mexico (NM) and these lease process delays are of significant concern to facility and Veterans Integrated Service Network (VISN) 18 leadership. Setbacks in particular locations such as Raton, NM, occurred while seeking leases for facilities that would enable the level of care our Veteran clients deserve. Five lease extensions were recently executed and VISN 18 leadership is taking swift and strong action to improve contracting for leases so that every patient in every clinic receives the highest level of care possible. Enclosed is a fact sheet that provides details on the status of leases in New Mexico.

Prior to 2008, contracting officers (COs) in VISN 18 operated in a decentralized model at each medical center, and the COs accomplished both contracts and leases, functioning in a generalist approach to tasks. The Network Director determined that creating centralized VISN-wide teams specializing in areas such as leases, construction, and medical sharing would be more productive and enhance staff skills in these complex areas. As part of this centralized approach, 19 additional staff were approved including a Deputy Contract Manager position established to improve oversight in NM and west Texas. The Deputy was hired in October 2009, and one of her top priorities is to manage the lease program to assure activities are completed timely and in accordance with prioritized needs. Directed and streamlined attention to the leasing process will expedite the implementation of proposed new lease contracts.

VA is committed to providing quality services to rural Veterans. In addition to the planned clinic expansions, there have been many advances in service across NM over the past three years. These include: implementation of state-of-the-art Telemedicine equipment used for Tele-mental health in eight CBOCs; implementation of teleretinal cameras to provide retinal exams for diabetic patients in five CBOCs; and increased implementation of Care Coordination Home Telehealth (CCHT) care. The CCHT program provides devices for Veterans to use in their own home to communicate health status to dedicated physician and nursing staff at the Albuquerque VA Medical Center, minimizing the need to travel for care. An average of 177 patients used this program on a daily basis in 2009, and additional funding of $2.3 million will be used to further expand this program in 2010.

VA will continue to explore and implement methods to better serve Veterans in rural areas of New Mexico, minimizing the need for travel wherever possible.

DEPARTMENT OF VETERANS AFFAIRS (VA)

FACT SHEET

STATUS OF NEW MEXICO COMMUNITY BASED OUTPATIENT CLINIC (CBOC) LEASES

Artesia: Extension of the current lease was executed on January 1, 2010, and will expire on December 31, 2010. A new lease for expanded and improved space will be awarded with occupancy no later than December 2011.

Farmington: Extension of the current lease was executed on January 1, 2010, and will expire on December 31, 2010. A new lease to expand and relocate to improved space will be awarded with occupancy no later than June 2011.

Gallup: The current lease expires on February 28, 2013. A new lease for expanded and improved space will be awarded with occupancy no later than February 2013.

Raton: Extension of the current lease was executed for a start date of February 1, 2010, and will expire on January 31, 2011. Contracting is currently procuring the new lease for expanded and improved space, which is anticipated to be awarded by June 2010, with occupancy by January 2011.

Rio Rancho: This is a new lease procurement. Contracting will begin the procurement process in February 2010; anticipates an award by July 2010, and occupancy by January 2011. The Business Plan originally developed for this CBOC, approved in June 2008 using Capital Asset Realignment for Enhanced Services (CARES) Priority CBOC criteria, underestimated demand by Sandoval County Veterans. With the addition of anticipated demand for specialty care and dental services, it was necessary to revise the Business Plan space requirements and seek approval on the corrected plan, which was received during the third quarter of Fiscal Year 2009. The

VISN has strengthened their Strategic Planning process to more accurately project workload growth in order to avoid such situations in the future.

Santa Fe: The current lease expires on October 31, 2012. An additional 800 square feet to expand the CBOC at the same location for Mental Health services was procured on January 1, 2010, to temporarily address needs. A new lease for improved space will be awarded with occupancy no later than October 2012.

Silver City: Extension of the current lease was executed on January 1, 2010, and will expire on December 31, 2010. An additional extension will be issued on January 1, 2011, until December 31, 2011. The lease for new space will be awarded on December 1, 2010, for anticipated occupancy of January 1, 2012.

Veterans Health Administration
January 2010

Chairman AKAKA. I would like to call the second panel.

Mary A. Curtis of the Boise VA Medical Center, testifying on behalf of the American Federation of Government Employees.

Tim McClain, President and Chief Executive Officer at the Humana Veterans Health Care Services. Mr. McClain served previously as VA general counsel.

Marjie Shahani, Chief Executive Officer at QTC Management, Incorporated.

John L. Earnest, President and Chief Executive Officer of the Ambulatory Care Solutions.

I want to thank all of you for being here this morning. Your full testimony will appear in the record.

Ms. Curtis, will you please begin with your testimony.

STATEMENT OF MARY A. CURTIS, APRN, BC, BOISE VA MEDICAL CENTER, REPRESENTING THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Ms. CURTIS. Chairman Akaka, Ranking Member and Members of the Committee. Mary Curtis is my name. I have been employed at the Boise VA since 1989. I am a long-timer I guess you would say. I am a Psychiatric Clinical Nurse Specialist since 1997. I am also a Clinical Application Coordinator working with the information technology department and closely working with CPRS which is our Computerized Patient Record System, our electronic medical record. I am on numerous committees including quality management and process improvement.

I am really concerned about the way the VA has been using more fee-basis care than it needs to. The VA providers do the best job; they do a great job and are much more experienced in the unique needs of the veterans. But due to staff shortages our capacity has not kept up with the need.

I did hear testimony earlier about C&P exams being contracted out. We are fortunate at Boise. Although a very small community, we do not contract out our C&Ps. We hire retired physicians from the community and bring them in as VA employees. They are on a part-time basis. They seem to really enjoy doing this.

They use our computer software which interacts very closely with CPRS, so that really improves the quality of the exams.

But back to the other contracting issues. I will bring up an example of our dental services. Our veterans could easily be treated by a part-time endodontist within the VA. This would not only save money but it would also eliminate the convoluted process required to contract out the care and then finalize the payment.

If a veteran is seen by our VA dentist and then requires more dental work, a consult and an authorization paperwork have to be filled out while the patient is still there. Then the VA staff contacts the fee-basis provider for an appointment and to verify the treatment plan.

Many times the reimbursement needs to be negotiated too because the VA cap for dental services in Idaho is lower than the VA cap for dental services in eastern Oregon, which is part of our catchment area.

Later with the patient in the contract dentist's chair, the VA may be contacted to authorize additional procedures which increase the dentist's reimbursement but may actually not always be needed.

Our person who authorizes sometimes feels kind of trapped to go ahead and authorize that payment since the patient is in the dentist's chair.

So, I surely hope that the VA implements the recommendations that the IG made to make sure that the fee-basis program is properly authorized and reimbursed.

I am also concerned about Project HERO, which has been up and running in the Boise VA for over 2 years now. AFGE received a briefing from the HERO program office last week, but, unfortunately, a lot of data they provided was incomplete and confusing. Overall the briefing raised a lot more questions than it really did answer.

There is so much we do not know about this project. Management gets regular briefings but those who are actually providing the care have never gotten a briefing.

No one has ever asked our opinion about the HERO contractors prior to renewing their contract to second and third years.

Basically, those of us on the front lines are pretty much kept in the dark when it comes to Project HERO even when it affects the veterans we care for.

When we are contacted by the patients who have been referred to HERO and have questions or problems, we are not allowed to intervene or talk directly to Humana or to Delta Dental to smooth things out. All we can do is transfer the veteran to our fee-basis office.

I really think that the veterans and the VA health care system would be better served if the clinicians on the front lines, myself included, were involved more in the contract care process and received training on how this process actually should work.

My colleagues in VISN 23 tell me that their directors have mandates to send all contract care referrals through Project HERO first even when we have a fee-basis provided we already know and trust lined up.

If HERO cannot find a network provider, the veteran's care is delayed until they can find one or decide that the case has to be sent back to the VA.

In my VISN, which is VISN 20, there has been a similar push to use HERO over our own fee-basis providers during the last 2 years. HERO claims that they save the VA about $3 million, but it appears that they charge referral fees for each appointment they arrange even if they call them "fees for value-added services" like

appointment setting, clinical information return, and claims payment, which are not applied to really the reduced savings.

They say they are increasing access for rural veterans, but HERO has sent some of our veterans hundreds of miles away for procedures that could have been done in the community with closer fee-basis providers or even right at the VA if we were fully staffed.

The problem is Humana has not been able to build a big enough rural network. I suspect that many providers are unwilling to contract with Humana or Delta Dental because of their low reimbursement rates and other contract terms.

This is really in the news lately with the million med march that is coming tomorrow—providers being unhappy with the Medicare fees, Medicaid fees, let alone reduced fees from other companies.

Humana also sold this project to VA based on the promise that it would improve access for our rural veterans, but in fact, Project HERO is taking over a lot of care for our veterans in the urban areas.

Boise VA is sending veterans to Project HERO for dermatology, GI procedures, audiology and podiatry regardless of where they live because the VA is short-staffed.

I maintain a part-time private practice myself in the community in addition to my full-time VA job. I was very surprised when I was contacted by Humana to join the Project HERO provider network since my office is only five miles away from the VA.

In fact, HERO claims that veterans referred to them travel roughly the same distance as fee patients. So, why are we paying HERO all these extra fees? And that is in their handout here.

HERO also claims that veterans are better off under HERO because all clinical information is sent to the VA within 30 days. But the HERO provider has to first send the records through Humana, which increases the risk of delay and lost records.

In contrast, when care is provided inside the VA all providers have immediate access to the full electronic medical record.

HERO touts higher patient satisfaction scores, called SHEP scores, than the VA; but HERO also acknowledges that, although similar, these measures should not be used as direct comparisons between Project HERO and SHEP satisfaction scores.

So, this is only one of many areas where the HERO program made confusing or unsubstantiated claims. And I must say also that the Boise VA SHEP scores are much higher than what was claimed in the Project HERO data.

In closing, I hope Congress will demand more oversight of the HERO Program and do an independent investigation of its claims about producing great benefits for veterans within the VA.

I would really like to see the VA return to a time where they only used contract care as Congress intended, that is, only when the care was truly not available through the VA system—where direct patient services would be fully staffed and adequately funded with an educated staff. Thank you.

[The prepared statement of Ms. Curtis follows:]

PREPARED STATEMENT OF MARY A. CURTIS, APRN, BC, PSYCHIATRIC CLINICAL NURSE SPECIALIST AND CLINICAL APPLICATION COORDINATOR, BOISE VA MEDICAL CENTER, BOISE, IDAHO, ON BEHALF OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Chairman and Members of the Committee: Thank you for the opportunity to share AFGE's concerns regarding VA contracts for health care services. My name is Mary A. Curtis. Since 1997, I have worked as a Psychiatric Clinical Nurse Specialist at the Boise (Idaho) VA Medical Center, one of the facilities participating in Project HERO. I am also a Clinical Application Coordinator working with computer applications, including the Computerized Patient Record System. I work closely with Quality Management identifying external peer review and Joint Commission issues. I also have a private practice in the community as an advanced practice nurse.

OVERUTILIZATION OF CONTRACT CARE

AFGE is a long time supporter of the veterans' *Independent Budget* (*IB*). Every day, my colleagues and I on the front lines of the VA health care system strive to achieve the health care principles of the *IB*: ensuring that veterans have access to timely, high quality care and a full range of services from a health care system that focuses on specialized care, conducts veteran focused research and supports health professional education.

As a mental health provider caring for veterans in a highly rural state, I frequently experience the challenge of providing veterans with adequate access to health care—a challenge that has increased with the growing number of rural OIF/OEF veterans returning home.

Health care contracts are one of many tools available to the VA to increase access for rural veterans and address other gaps in care. The Veterans Health Administration (VHA) Office of Care Coordination Services has a highly developed Telehealth program. The Office of Rural Health is focusing on education and training, workforce recruitment and retention and new technologies to develop innovative solutions to rural access problems. AFGE thanks Chairman Akaka and Senator Begich for introducing the Rural Veterans Health Care Access and Quality Act of 2009 (S. 734) to attract more health care providers to rural areas and increase quality controls over contract care.

The Boise VA has a strong Community Care Home Telehealth program which treats veterans with congestive heart failure, diabetes and other chronic conditions utilizing remote equipment for blood pressure readings and other tests. We also use telehealth for our implantable defibrillator clinic. Our mental health team travels to the Community Based Outpatient Clinics (CBOC) and other outpatient settings to provide care. Our Vet Center has a new mobile clinic that is able to reach veterans in rural areas.

When choosing between contract care and other means of providing care to rural veterans, the VA should balance the benefits of contract care against its risks. Contract care requires that the VA give up a certain degree of control to a for profit outside entity. In the short term, the effect is that the VA may be less able to control costs, quality of care, provider qualifications and medical privacy or ensure that care is delivered timely and is geographically accessible. In the long term, excessive use of contract care may deplete the VA health care system of the staff, equipment and other resources it needs to continue to provide veterans with a full range of services. The diversion of large numbers of veterans to contract providers may also weaken VA's research capacity and academic affiliations.

Congress clearly recognized the risks of sending veterans outside the VA for care, limiting the use of health care contracts to specific circumstances: geographic inaccessibility, lack of in-house capability to furnish the type of care required and medical emergencies (38 U.S.C. §§ 1702, 1725 and 1728).

Unfortunately, medical center directors seeking short term fixes for patient wait lists and staff shortages often ignore these criteria and opt for fee basis and other costly contract care arrangements without adequately considering alternatives that would better serve the veteran and VA health care system. As a result, contract care is over-utilized and under-scrutinized by many VA medical facilities in both rural and urban areas.

FEE BASIS CARE

Many medical center directors justify the increased use of costly fee basis care in recent years as the only means of providing care to veterans in a timely manner and accessing specialty care, in the face of physician recruitment and retention

problems. As a result, management may end up paying more on a fee basis that it would cost to attract providers to the VA workforce.

AFGE members report that the increased use of fee basis care is causing budget shortfalls at a number of facilities, despite record funding increases by Congress. Cost overruns from fee care produce a vicious cycle: directors impose hiring freezes and defer equipment purchases, which trigger the need for more costly contract care.

The Boise VA would be able to reduce a large number of fee-basis consults if we had more providers on staff. Although Boise is a smaller facility, we still have a GI clinic staffed by in-house providers who perform colonoscopies. Due to limited staffing and space, a high number of these procedures have been sent out to the community. Our dental department is also short staffed.

We commend the VA Office of the Inspector General (IG) for its comprehensive study of the VA Fee Program (VA OIG Report No. 08–02901–185). The IG found that the fee program is "complex, highly decentralized and rapidly growing," with extensive noncompliance with requirements for justifying and authorizing fee services. AFGE strongly endorses the IG's recommendation that VHA strengthen controls over this program to reduce payment, justification and authorization errors.

PROJECT HERO

This pilot project is supposed to manage VA contract care more effectively than the VA can manage it with its own staff and infrastructure. Project HERO essentially injects for profit contractors into the contract care process as the intermediary between the VA and veterans who may need to be referred outside the VA for care.

Both the implementation and ongoing operations of Project HERO have been conducted largely behind closed doors. Based on the limited objective data available and observations by our members in facilities participating in HERO, it appears that HERO has little or no "value added:" HERO contractors are simply not doing a better job managing contract care than the VA.

In fact, there are early signs that the insertion of another layer in the contract care process and the use of for profit care coordinators have delayed care, left veterans confused and dissatisfied, required some veterans to travel further and depleted VA's internal capacity to directly manage fee basis care (in addition to the larger budget problems resulting from increased spending on contract care, as already discussed.)

It also appears that HERO contract care referrals cost the VA more than fee basis referrals it makes directly. The HERO program pays its network providers less than they would be paid if they were contracting directly with the VA under its fee basis program. Then, it appears that HERO contractors bills the VA at a higher rate and also tacks on hefty referral fees.

HERO has failed to build adequate provider networks, especially in rural areas where the need is greatest. In fact, it appears that providers are reluctant to do business with HERO contractors (especially given the low reimbursement rate already mentioned). For example, last year, the Idaho Medical Association cautioned its members about the problematic terms of the Humana provider contract. An AFGE nurse involved with contract care at another VISN 23 participating facility reported that several dialysis providers refused to contract with Humana. Last year, VISN 23 data indicated that the vast majority of veterans referred to HERO had to be referred back to the VA because HERO providers were not available.

We have seen no justification for awarding contracts to Humana and Delta for all four pilot VISNs; the use of a different contractor in each VISN would have yielded useful comparative information and may have better served the unique needs of each area.

Similarly, despite AFGE's request, HERO has provided no justification for renewing the Humana and Dental contracts of the second and third years. (The third pilot project year begins on October 1, 2009; HERO has the option to renew these contracts for a total of five years.)

AMONG THE CRITICAL QUESTIONS THAT REMAIN UNANSWERED:

- How much is Project HERO costing the VA in terms of program administration at the national, VISN and local facility levels? The *Nation* magazine (April 9, 2008 issue) described HERO as a $915 million program, but AFGE is not aware of any specific appropriations for the program.
- What does HERO cost the VA compared to fee care arranged directly by the VA? What do HERO contractors charge the VA for different medical services, and how are referral fees set?

• What share of VA provided care and VA fee basis care has been shifted to HERO? Last year, HERO program officials reported to the media that the program covered 30% of all veterans enrolled with the VA. At a September 23rd briefing for AFGE, HERO program staff told AFGE that "HERO contract use is less than 2% of VA unique outpatients receiving medical care."

• What criteria were used to award Humana and Delta Dental an exclusive contract for all 4 pilot VISNs? What criteria were used to renew these contracts year?

It does not appear that Project HERO has achieved any improvements in the Boise VA's fee basis program. The Boise VA has had a good relationship with contract providers within our catchment area, including dentists for our OIF/OEF veterans. But Project HERO has made arrangements with providers for reimbursement of less than the Medicare rate and it can be difficult to find willing providers within a reasonable distance. For example, a veteran referred to HERO was expected to get his colonoscopy 500 miles away from his home.

At Boise, the use of an outside entity to arrange contract care has added another unnecessary administrative layer for staff who act as liaisons between patients and community providers. VA staff is prohibited from contacting Humana when patients have questions or need to change their appointments. All we can do is refer them to Fiscal Services. We are not allowed to give any phone numbers to the patients. As a result, patients get very frustrated and upset with us, but there isn't much we are permitted to do to assist them.

Also, Project HERO dentists in the Boise area have refused to see a patient until additional procedures are approved in order to increase their reimbursement, which has not been a problem with local contracts under the fee program.

CONCLUSION

On July 29, 2009, the Office of Management and Budget directed Federal agencies to end their overreliance on contractors, conduct an inventory of their in-house and contract workforces, and bring appropriate work back into the government. AFGE urges the Committee to ensure that the VA aligns its health care contract policies with this historic new directive, including an inventory of all pending contracts for health care and an assessment of contract care functions are more appropriately performed in-house.

More specifically, through Project HERO, the VA has outsourced a function that has traditionally been performed in-house: determining whether a veteran should receive medical care from an outside provider rather than the VA. Second, the VA has outsourced the operation of a large number of CBOCs; the IG recently identified a number of problems associated with contract outpatient clinics (Report Number 09–01446–226, 9/23/2009). Third, Congress continues to authorize the use of contractors to conduct C&P exams for disability claims, despite mixed evidence of using the benefits of using a for profit contractor rather than providing the VA with additional staff and training to perform more of these exams in-house.

AFGE also recommends joint labor-management training on the VA fee program. Informed staff working on the front lines of VA health care can play a valuable oversight role in assessing whether fee basis determinations are properly justified and authorized.

Finally, Congress should withhold funding for the fourth and fifth option years of Project HERO and any further expansion of the pilot pending an investigation of its actual costs, its impact on health care quality and access, and on VA's internal capacity to manage contract care. We commend Senate appropriators for including HERO oversight language in the FY 2010 VA appropriations bill report (Senate Report 111–040), and urge this Committee to ensure that the VA complies with the requirement to report to Congress by October 30, 2009.

Thank you for the opportunity to testify on this issue.

Chairman AKAKA. Thank you very much, Ms. Curtis.

Mr. McClain.

STATEMENT OF TIM S. MCCLAIN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HUMANA VETERANS HEALTH CARE SERVICES

Mr. MCCLAIN. Thank you, Mr. Chairman.

I am Tim McClain, President and CEO of the Humana Veterans Health Care Services, Inc., the contract partner with VA in Project HERO.

I am accompanied today by my Chief Operating Officer, Mr. Brad Jones, and also present is Joanne Webb, a member of our advisory board and a tireless advocate for veterans.

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

As you are aware, the veteran-friendly concept for Project HERO was congressionally inspired. VA was asked to develop a pilot project in partnership with a commercial company to focus on improved administration and outcomes for veterans referred to community providers for specialty health care or other services.

Through collaborative efforts and a close partnership, Humana Veterans and VA concentrated on three areas that became the hallmarks for Project HERO: quality health care services; timely access to care; and cost-effective care.

The collaboration with VA has resulted in what we described as the HERO model. The model is more fully described in my written statement, but it is specifically designed to enhance the veteran's overall experience and ensure the quality of health care delivery by a community provider.

Since my arrival at Humana Veterans as CEO in July of this year, I have emphasized that the model must be veteran centric. I can best describe the theory of the HERO model as an extension of the respect and atmosphere shown to veterans within VA's four walls.

Many veterans feel a special sense of belonging when they are in VA facilities as they are surrounded by other veterans and VA's very caring staff. That feeling may go missing for the most part when a veteran goes into the civilian community.

The Project HERO model is designed to metaphorically place a firm but gentle hand on the veteran's shoulder and guide the veteran through the maze of care outside VA. The hand remains on his or her shoulder until the veteran returns to the primary care VA doctor.

During the journey the veteran receives various personalized services that comprise the HERO model, as I stated in my written statement.

The employees of Humana Veterans are proud of what we have accomplished in the past 21 months. However, we realize that there have been bumps and hurdles along the way and certain individuals and organizations have expressed concern about Project HERO. Through collaboration and innovation, we are working through each of the concerns and issues with our VA partners.

For example, although not required in the written contract, we have implemented a data repository, called "Data Mart." One of the major advantages of the Project HERO model is data availability and accountability through the contract metrics.

Another advantage is the planned online issue resolution system that is under development at Humana Veterans. Issues raised at any VA site by veterans, by the fee office, or indeed by Humana Veterans, will be given a tracking number, assigned to a responsible office, and tracked until a resolution has been formed and implemented. In our view, each issue resolved contributes to better quality health care for veterans.

One significant issue we have identified is the unexpected low volume of HERO utilization in the four demonstration VISNs. We believe the HERO model has now developed to the point where an increase of referral volumes is required to fully test the HERO model.

I want to emphasize this is not an increase in outsourced care. The fee office decides whether to send a preauthorized veteran to regular fee-based care or to Project HERO. So, we are simply asking for an increase of the number of veterans already going into community care to go to HERO.

We encourage the Committee to recommend VA fully engage in this demonstration project to show what a true veteran-centric model can do for veteran services in the community.

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

[The prepared statement of Mr. McClain follows:]

PREPARED STATEMENT OF TIM S. MCCLAIN, PRESIDENT AND CEO, HUMANA VETERANS HEALTHCARE SERVICES, INC.

INTRODUCTION

Chairman Akaka, Ranking Member Burr, 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 services for Veterans; 2) timely Access to care; and, 3) Cost effective care.

I am President and CEO of Humana Veterans, the contractor 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.

HUMANA VETERANS BACKGROUND

Humana Veterans, headquartered in Louisville, Kentucky and incorporated in 2007, was established to develop and implement solutions for Veterans' health care issues. It provides an organizational structure that is flexible, agile, and responsive to the emerging requirements of the Department of Veterans Affairs and the Veterans who rely on VA services.

OVERVIEW OF PROJECT HERO CONTRACT

Project HERO is a demonstration project (pilot) currently implemented in four Veteran Integrated Service Networks (VISNs). 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 timely access to care, quality of care, and preserve the fiscal integrity of VA health care expenditures, while maintaining high customer satisfaction. Project HERO has succeeded in all of these areas.

As displayed in the map in the attached Appendix, 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.

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 eighteen months of working diligently with our partners at VA, we believe we are delivering on these objectives.

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 patients within 30 days of receipt of the referral by the provider and the provider will see patients within 20 minutes of their scheduled appointment.

Accreditation

Unless a waiver exists, all network providers 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 patient'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 patient safety events are investigated, confirmed, and resolved and we keep the VA informed of the progress in resolving patient safety events.

Patient Satisfaction

Humana Veterans designated a Patient Advocate with the responsibility of receiving patient 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 we assist patients 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 PMO or Fee Office at the VAMC level has access to the data and may pull reports on the metrics, after they have been granted access by the Contracting Officer Technical Representative.

MISCONCEPTIONS

Mr. Chairman, now that I have established the rationale for the development of the demonstration, at this point I feel it is also very 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 we think 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 efficient health care services to our Nation's Veterans.

PROJECT HERO MODEL

Humana Veterans, in collaboration with VA, coordinates quality, timely health care services through Project HERO. VA refers patients to civilian 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 both VA and Humana Veterans, with contract metrics tracked and reported on a monthly basis.

The Project HERO Model includes a personalized service process for Veterans and is outlined below.

(1) 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 civilian provider.

(2) 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.

(3) The CCR then conducts a three-way conference call with the veteran and a Humana Veterans network provider's office. This call occurs within five 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.

(4) 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.

(5) 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.

(6) 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 15 days.

(7) 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.

(8) 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.

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 27,000 providers across the four VISNs. 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, we nonetheless believe 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% 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 ongoing relationships with provider groups.

It is important to state at this point that even if the cost was 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 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 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 civilian 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.

We at Humana Veterans believe the Project HERO Model delivers on each of these quality indicators.

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 an-

other 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 August 2009 shows:

- Seventy-two percent (72%) of clinical information is returned within 15 days.
- Eighty-eight percent (88%) return of routine clinical information to the VA within 30 days of the HERO encounter;
- Ninety-two percent (92%) return of routine clinical information within 45 days
- On average, clinical information is returned to VA within 15 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.

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 recredentialing of contracted providers is conducted at least every three 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 quality 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 Data base (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.

FUTURE OF THE HERO MODEL

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 six months. It would be difficult to draw many conclusions on the ultimate future of HERO without a true test of its capabilities. The current monthly volume of referrals has fallen below 6,000 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 expected to double over the next five 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.

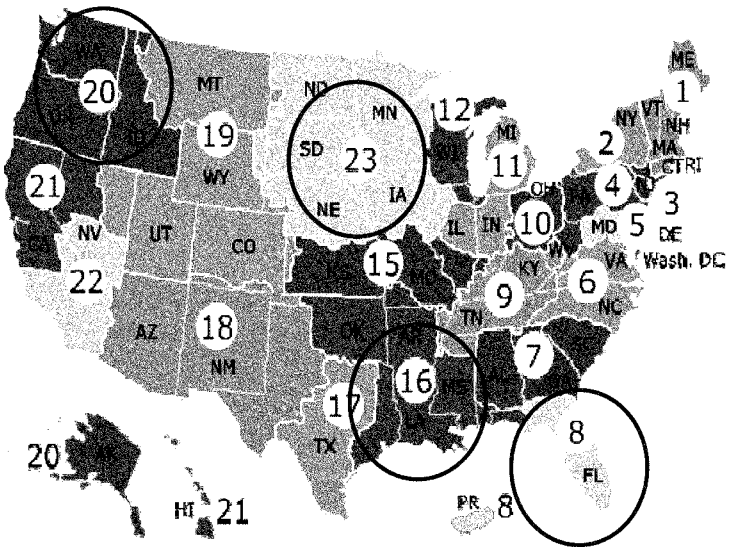
(3) Finally, we have made great progress ensuring Veterans' clinical information is returned in a timely fashion to the VA after a clinical encounter with a HERO provider. It would be more effective if we could provide it electronically through VistA and have it compatible with CPRS as the VA is at the 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.

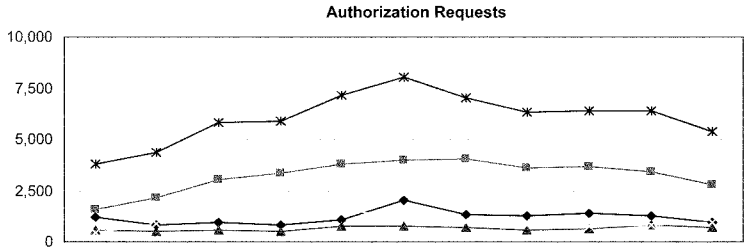
CONCLUSION

Mr. Chairman and Ranking Member Burr, 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 services and that is our ultimate mission at Humana Veterans.

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

APPENDIX





	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09
VISN 08	1,195	799	965	834	1,057	2,016	1,311	1,297	1,377	1,269	927
VISN 16	1,603	2,136	3,064	3,369	3,828	3,959	4,073	3,613	3,649	3,405	2,813
VISN 20	575	537	554	499	784	790	710	554	632	849	687
VISN 23	444	902	1,235	1,167	1,500	1,293	959	850	756	838	926
Project Hero	3,817	4,374	5,818	5,869	7,169	8,058	7,053	6,314	6,414	6,361	5,353

Chairman AKAKA. Thank you very much, Mr. McClain.
Ms. Marjie Shahani.

STATEMENT OF MARJIE SHAHANI, CHIEF EXECUTIVE OFFICER, QTC MANAGEMENT, INC.

Ms. SHAHANI. Good morning, Chairman Akaka and Members of the Committee. Thank you for the opportunity to testify this morning. QTC provides compensation and pension medical examinations and administrative services to VBA in support of ten VA regional offices.

Our contract with VBA is to provide medical evidence that is used by the VA rating specialists to determine a veteran's disability rating.

Our testimony today addresses the Committee's request to understand how this VA contract ensures both high-quality and cost-effective services.

Our VA contract is a performance-based contract with financial incentives and disincentives. The intent of performance-based acquisitions is to encourage contractors and the government to work together to achieve the contract objectives and provide the best services to our customers, the veterans and servicemembers.

The VA contract ensures high-quality services through both performance requirements and performance metrics. Performance requirements include: using licensed and credentialed physicians and other specialists to conduct medical exams; adherence to over 50 VA exam protocols which are also used by VA medical center providers who perform C&P exams; and a quality assurance program to ensure exam reports comply with VA requirements.

There was a question about training earlier. Training doctors regarding VA programs, how to conduct a C&P exam and on the differences between disability and treatment protocols are included in the requirement.

Performance metrics in our contract include standards for timeliness, quality, and customer satisfaction that were discussed by Mr. Mayes. Timeliness standards provide VBA with timely delivery of the exam reports and support efforts to improve average claims processing timeliness.

The timeliness standard is 38 days on average from receipt of exam request to report delivery, and it is measured at the VA VERIS system. Quality standards ensure examination reports are complete and can be used by the VA rating specialist to make a sound rating decision.

The quality standard is a minimum of 92 percent defined as complete adherence to VA exam protocols, and is measured by VA through a random sample of reports on a quarterly basis.

Customer satisfaction standards are used to determine the veteran's overall satisfaction with QTC service. Satisfaction is measured by a survey of each veteran, as mentioned. Responses are tracked by an independent third party.

There are two metrics. Veterans are to be seen within 30 minutes of their appointment a minimum of 90 percent of the time, and veterans must be satisfied with QTC services at least 92 percent of the time.

I am proud to state that QTC has met or exceeded timeliness and quality standards in the last 25 quarters and has achieved 100 percent of customer service standards for the past 6 years.

There was a question about the cost of contractor services. The Committee should be aware that the contracted cost of C&P medical exam services include more than the cost of the exam itself.

Associated program costs are also included such as scheduling the appointment, mileage reimbursement, management of the veteran's case file, expert quality review, provider credentialing and training.

In addition to ensuring high-quality, the VA contract ensures cost-effective services through three mechanisms. One is a competitive contracting process. By following the Federal Acquisition Regulation for full and open competition, VA is able to receive a competitive price.

Two, paying for services only when they are needed. The volume of exams based on our experience in any given week or month, the number of claimed conditions for each veteran, and the location of veterans including remote and rural areas, all vary dramatically. Permanently staffing for these variances at locations would be extremely difficult and costly for any medical entity.

And three, paying for services when they meet or exceed contract standards. Financial penalties are assessed when performance does not meet the standards.

In conclusion, our VBA contract contains stringent performance requirements and metrics and is designed to incentivize quality and cost-effective services.

Our contract is successful as a result of our high level of performance and the extraordinary role our VBA customer has displayed in achieving the objectives.

We are dedicated to serving veterans and active duty servicemembers, and we have invested the time and resources to automate the exam protocols and process to positively impact the experience of our veterans.

We are proud to have played a role in VBA's mission in providing quality and timely C&P services. We have enjoyed our partnership with VA as we work collaboratively to serve our Nation's heroes.

Thank you again for the opportunity to testify here today, Mr. Chairman.

[The prepared statement of Ms. Shahani follows:]

PREPARED STATEMENT OF MARJIE SHAHANI, MD, CHIEF EXECUTIVE OFFICER, QTC MEDICAL SERVICES, INC.

Good morning Chairman Akaka, Ranking Member Burr and Members of the Committee. On behalf of QTC Medical Services, Inc. (QTC), I would like to first and foremost thank you for the opportunity to discuss our support of the Department of Veterans' Affairs (VA's) Compensation and Pension Service, and how we provide medical examination services to the VA in a cost-effective and high quality manner. We have been honored to serve our Nation's veterans and active duty servicemembers since 1998. We consider ourselves a partner of the VA and are committed to providing excellent quality, timeliness and customer service to the VA and to our Nation's veterans and servicemembers.

QTC was founded in 1981. Over the past 28 years, we have grown to be a nationwide provider of disability and occupational health evaluation services. QTC has long-term contracts with Federal, state and local government agencies and manages a nationwide credentialed network of private health care providers.

QTC provides Compensation and Pension (C&P) medical examinations and administrative services to the Department of Veterans Affairs in support of 10 VA Regional Offices in 9 states consisting of Texas, Oklahoma, Massachusetts, Virginia, North Carolina, Georgia, Washington, Utah and California. Our contract is with the Veterans Benefit Administration (VBA) to provide the medical evidence used by the VA Rating Specialists to determine the disability rating of a veteran. The primary contract deliverable is the narrative report and associated results from a medical examination performed in accordance with VA requirements.

Our testimony today addresses the Committee's request to understand how this VA contract for C&P medical examinations ensures both high quality and cost effective services.

The VA contract is a performance-based contract with financial incentives and disincentives. The intent of performance-based acquisitions is to encourage contrac-

tors and the Government to work together to achieve the contract objectives and provide the best services to customers—veterans and servicemembers.

The VA contract ensures high quality services through performance requirements and performance metrics. It describes the required results in clear, specific and objective terms with measurable outcomes as well as the method for monitoring performance. The management of contract performance is guided by the contract's terms and conditions and is achieved with the support of the business relationships and communications established between QTC and the VBA.

Performance requirements include:

- Conducting medical examinations using licensed and credentialed physicians, audiologists, psychologists, optometrists and other specialists as applicable.
- Adherence to over 50 VA Automated Medical Information Exchange (AMIE) worksheets which are also used by VA Medical Center (VAMC) medical providers performing C&P exams.
- Quality Assurance program to ensure that exam reports comply with VA requirements for a ratable report.
- Training program for examiners regarding VA programs, conducting C&P exams and differences between disability and treatment protocols.

Performance metrics include standards for timeliness, quality and customer satisfaction. The contractor must meet or exceed the defined standard for each metric. QTC monitors its operational metrics on a daily basis and the VBA formally measures and report results to QTC in Quarterly Performance Reports.

Timeliness standards provide the VBA with timely delivery of exam reports to support their efforts to improve average claims processing timeliness:

- The standard is 38 days average cycle time from receipt of exam request to submission of final exam report to the VBA.
- It is measured by quarterly reports from the VA's Veterans Examination Request Information System (VERIS).

Quality standards are used to ensure examination reports meet AMIE worksheet requirements needed for VA Rating Specialists to complete rating decisions:

- The standard is a minimum of 92% quality defined as complete adherence to, VA's AMIE worksheets.
- It is measured by quarterly reviews of a random sample of exam reports performed by the VA Medical Director and VA Central Office rating experts.

Customer satisfaction standards are used to determine the veteran's overall satisfaction with QTC's services to include scheduling, appointment notification and the examination itself:

- Satisfaction is measured by a customer survey provided to each veteran that is tracked by an independent third party under contract to the VA. Results are provided to QTC quarterly.
    - o Metric 1: Veterans are seen by the examiner within 30 minutes of their appointment.
        - The standard is a minimum of 90% of veterans are seen by the examiner within 30 minutes of their appointment.
    - o Metric 2: Satisfaction scores on contractor's services.
        - The standard is a minimum of 92% of respondents are very satisfied or somewhat satisfied responses.

In addition to the contract requirements and performance metrics, QTC imposes its own extensive internal quality assurance processes to every aspect of the contract from scheduling the examination to submission of the complete medical report to the VBA. We are focused on consistent achievement of the contract objectives and strive for continual improvement.

Effective contract management by the VBA and QTC, ongoing oversight by the VBA and constant dialog and communication assures the focus on results. Formal monthly reports and meetings between VBA and QTC are used to track achievement toward the performance metrics and discuss upcoming exam needs to assist planning efforts.

The VA contract ensures cost-effective services through three mechanisms:

(1) A competitive contracting process,
(2) Paying for services only when they are needed, and
(3) Paying for services only when they meet or exceed contract performance standards.

The contract ensures cost effective services by following the Federal Acquisition Regulations (FAR) for full-and-open competition requirements. Through a competi-

tive contracting process, the VA receives a competitive price for the services it requires.

The Committee should be aware that the contracted cost of C&P medical exam services includes more than the cost of the medical examination. Associated medical administrative activities are also included, such as scheduling, management of the veteran's case file, expert quality review, provider credentialing and training. The contract specifies that contractors are to charge the VA a fixed price per examination to include fully loaded labor costs, fringe benefits, equipment, locality adjustments, necessary reports, overhead, general and administrative and profit.

Contracting for C&P medical examination services provides an essential service as the volume of exams, the number of claimed conditions and specific location of the exams varies dramatically. Permanently staffing for these variances at all locations would be extremely difficult, and costly, for any medical entity or program office. The VA contract is a fixed price contract which provides the VBA complete control on ordering examinations as needed with no commitment of volume from the government to the contractor. Contracting for these services is a cost effective way to ensure the VA only pays for services when and where they are needed. The use of volume discounts on our contract also provides a mechanism for the VA to receive cost-effective services during periods with high examination requests.

Additionally, the contract performance requirements and metrics—that we have reviewed with you—ensure the VA only pays for high quality services and results. Financial penalties are assessed when performance does not meet the defined standard.

The VBA contract is designed to incentivize quality and cost-effective services. QTC is proud of the partnership that has been developed with the Department of Veterans Affairs while working together in achieving the contract objectives.

Finally, QTC believes the reasons this contract is successful include our performance over the past decade and dedication to our veterans and the VA's mission. Of equal importance is the twofold effort from VBA—to have effectively executed a performance-based contract with focused performance metrics and clear requirements, and the extraordinary role our VBA customer has played in working alongside us, providing ongoing communications, collaboration and support. We are partners: both working to provide excellent, ratable examinations for veterans filing claims for disability compensation—with quality, timeliness and veteran satisfaction.

Thank you again for the opportunity to testify today. I look forward to answering any questions you may have.

Chairman AKAKA. Thank you very much, Ms. Shahani.

Mr. Earnest.

STATEMENT OF JOHN L. EARNEST, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMBULATORY CARE SOLUTIONS

Mr. EARNEST. Thank you, Mr. Chairman, and I thank the Committee for the opportunity to testify in front of you.

My name is John L. Earnest. I am the President and Chief Executive Officer of Ambulatory Care Solutions. We are a small business and we are headquartered in Marion, Indiana.

In 2006 we received a call from the VA Secretary's office stating he wanted to visit one of our clinics in Bloomington, Indiana. We thought oh my gosh what did we do now.

Then 2 weeks ago we received a call from Dr. Andrea Buck stating that she would like for us to testify in front of your Committee, and here we go again.

We have always prided ourselves in flying under the radar screen, but it looks like the radar hit us today, so please bear with us.

Our senior management has been involved in physician staffing and practice management for over 30 years. When the Veterans Health Care Eligibility Reform Act came out in 1996, we looked at the Act and we thought there were some things that we could be doing in contracting with the VA.

Our first contact was in South Bend, Indiana, and that was in 2004. We now have six contracts which include Terre Haute, Bloomington, and Goshen, IN, and also St. Clairsville, OH, and Jonesboro, AK. We have over 25,000 veterans enrolled in these six clinics.

We are a small business, and as such, we have a management philosophy of being hands on. We want to maintain a conservative, managed growth strategy. We do not want to be exceeding our means when we go to contract with the VA.

There are two or three items we want to highlight today. One of them is the quality of care. First of all, there are multiple levels of oversight in terms of a CBOC that includes the parent hospital; it includes the Joint Commission; and most recently we were inspected by the Office of Inspector General.

The key point I want to make here is that as a VA contractor we operate in a fish bowl. By operating in a fish bowl, both VA and its contractors know that their operations are subject to a transparency that providers in the private sector never have to worry about.

Here is a copy of our Jonesboro contract. In that contract there are many performance measures and many reports that we supply on a monthly basis to the VA.

With regard to performance measures, in August 2004 after being in practice management for several years, I felt that I knew everything that there was to know about practice management. Wow, what a surprise.

What I found by working with the VA is the VA is ahead of the private sector in so many ways. This includes the electronic medical records, CPRS system. It includes the number of performance measures that we must attain on a monthly and quarterly basis, and we are graded on these performance measures.

All of our contracts have incentives or penalties involved with them—performance measures. The interesting thing is our incentive is 3 percent of a monthly bill if we attain a good score. Our penalty is 10 percent of a monthly bill if we do not attain a good score. Needless to say, we want the incentive and not the penalty.

In our opinion, the integration of performance measures make the quality of care in VA's primary care operations difficult to match in similar operations in the private sector.

From a contracting standpoint, we learned the hard way. We put in multiple bids and then we finally were able to get a contract. The single most important thing that the VA can do to promote greater interest in its contracting opportunities is to allow more time for proposal preparation.

In summary, we would like to say that the VA engineered a remarkable transformation over the last decade. Many times the VA does not tell its story. There is a high-quality of care that extends through its contractors.

Again we want to thank you for this opportunity and we also want to thank the Veterans Administration and Northern Indiana Health Care System, the Richard A. Roudebush VA Medical Center, the VA Pittsburgh Health Care Center, and the Memphis VA Health Care Center.

It is a privilege and honor to work with these professionals and we invite any Members of the Committee to join us at any time in any of our clinics.

Thank you.

[The prepared statement of Mr. Earnest follows:]

PREPARED STATEMENT OF JOHN L. EARNEST, PRESIDENT/CEO, AMBULATORY CARE SOLUTIONS, LLC

INTRODUCTION

Good morning. My name is John L. Earnest and I am the President and Chief Executive Officer of Ambulatory Care Solutions, LLC (ACS). ACS is a small business headquartered in Marion, Indiana. We currently operate six Community Based Outpatient Clinics (CBOCs) under contract to the Department of Veterans Affairs (VA).

We appreciate the invitation to offer comments to the Committee about VA health care contracts. While VA contracts for almost every different type of health care service imaginable, my comments this morning will be limited primarily to our experience under the VA's CBOC initiative.

Senior management of ACS has been involved in the operation of emergency care, urgent care and primary care clinics in the private sector for over 30 years. In previous positions prior to ACS, I was responsible for the recruitment and staffing of 85 hospital emergency department contracts and was involved in the startup of over 50 walk-in medical facilities east of the Mississippi, including the first urgent care center in the state of Indiana in 1980.

Following enactment of Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996, the legislation that gave the VA additional contracting flexibility, we began to notice the VA's expansion into community based primary care. My colleagues and I believed that our operational experience was directly relevant to the kind of care sought for veterans under CBOC contracts and that we were well-positioned to respond to this rapidly growing demand. Ambulatory Care Solutions was established in 2004 specifically to provide primary care for veterans through the CBOC initiative.

ACS was awarded its first CBOC contract in South Bend, Indiana in August 2004. Since then we have added contracts in Terre Haute, Indiana in February, 2006; Bloomington, Indiana, in March, 2006 and Goshen, Indiana in July, 2008. We were awarded our first CBOC contract outside of Indiana in St. Clairsville, Ohio in December 2008, and the contract for Jonesboro, Arkansas in April of this year. At the present time, through our six CBOC contracts in three states, we serve over 25,000 veteran enrollees and provide in excess of 125,000 patient visits annually.

ACS is a small business whose management philosophy is characterized by a "hands-on" approach. We emphasize on-site presence by senior management throughout the life of our CBOC contracts. We maintain a conservative managed-growth strategy that ensures we devote the time necessary to bring each new CBOC contract online smoothly. While ACS now looks carefully at most CBOC opportunities that come up, we have historically declined to pursue any new opportunity until we are confident that our existing contracts are running smoothly. We have actually withdrawn one of our bids after submission, as a result of simultaneous, but unanticipated changes in multiple procurement schedules, rather than proceed with a project where changes threatened our ability to deliver as promised. While this was a difficult management decision, it was one that we felt was ultimately in the best interests of veterans, the VA and ACS.

Although ACS is not veteran owned, we place a priority on recruiting and hiring vets at both the corporate level and each of our delivery sites. For example, ACS' Chief Financial Officer, Jerry Jones, is an Army veteran.

There are several key points I wish to emphasize in my testimony today about VA contracts for health services. They are as follows:

- To Contract or Not Contract? That is the Question . . . Under the right circumstances, contracting for a CBOC may be the best solution for veterans and the VA in a given market area.
- The Procurement Process is a Barrier to Entry—The procurement process is complex and serves as a significant barrier to entry for many qualified firms.
- Contract Operations—While we find the requirements of VA CBOC contracts to be very demanding, we believe that they ultimately serve to significantly enhance overall performance and quality of care.

• Contract Oversight—The potential for public oversight of most VA contracts is significant. In many respects, the degree of transparency now available to the public for CBOCs operated both by VA and by contract is unmatched in the private sector.
• Future Considerations—Improved access to veterans in rural and more remote areas through partnerships or relationships with local providers may call for the VA to relax some of the demanding contractual requirements that have been largely responsible for the agency's successful transformation over the last decade.

TO CONTRACT OR NOT TO CONTRACT? THAT IS THE QUESTION

One of the age old questions in every Federal agency responsible for providing some type of service is the perennial "make or buy" dilemma. This remains a complex question for the VA in particular, as the longstanding tradition of having medical care for veterans provided primarily by VA employees in VA facilities has been put to a challenge by economic rules that guide such decisions.

It was a much easier decision to make in the "old days" . . . when most health care for veterans was provided in inpatient settings. But as the demand for care shifted to outpatient settings, the economics changed as well. While we readily acknowledge and respect the preference on the part of many veterans and veterans' organizations for the privilege of being treated by VA staff in VA facilities, we know of no formula that incorporates the powerful emotional attachment to "our facilities" and "our staff" into the "make or buy" decision model. In general, we think that most constituencies, including veterans, Veterans Services Organizations, as well as Congress, ultimately recognize the need for, and benefits of contracting to supplement the VA's system of care in appropriate circumstances, but there remain pockets of strong opposition based on principle . . . if not economics.

It is much too easy to suggest that only VA itself can provide the quality of care and respect that veterans deserve, or, that, conversely, no contractor is capable of demonstrating the same degree of respect, concern or quality as veterans receive in VA facilities.

We think the most appropriate response to the "make or buy" question is what's best for the local veteran population in question on a case-by-case basis. So while the decision to have the VA staff and operate a CBOC in one location may be the right decision, the best solution in another location may indeed be a contractor-operated CBOC. Neither the VA nor its contractors have a perpetual "lock" on delivering high quality care. Issues can, and do arise from time to time, regardless of the source of care or location; the most important consideration is to put in place the management controls to continuously review and monitor performance so that it remains at or above target levels. VA does this for its own services, and those protocols extend to their contracted services as well.

VA utilizes a comprehensive evaluation process to make such make-or-buy decisions, as described in VHA Handbook 1001.6, Planning and Activating Community Based Outpatient Clinics. ACS carefully evaluates those opportunities where VA has decided that the best alternative is to acquire the services via contract.

THE PROCUREMENT PROCESS IS A BARRIER TO MARKET ENTRY

The Federal contracting and procurement process is a tremendously complex, highly bureaucratic, intimidating process that is always changing . . . and not for the feint-of-heart. That is a lesson we learned the "old fashioned" way. ACS submitted multiple bids over several years before we successfully entered this market. We have become more adept at the process since then. It wasn't easy then . . . and it remains a challenge to this day.

As an example, the last Request for Proposal (RFP) we bid on for a CBOC was 170 pages long, not including the hundreds of pages of internal VA documents cited in the RFP itself, or most of the Federal Acquisition Regulation (FAR) or VA Acquisition Regulation (VAAR) clauses cited "by reference". The latest printed version of the FAR is 1,969 pages and the VAAR, a "quick read" by comparison, turns in at a mere 370 pages. To its credit, part 873 of VA's own regulations provide "Simplified Acquisition Procedures for Health care Resources", although they are to be used "in conjunction with" the FAR and VAAR. When the level of complexity is combined with the limited time available to prepare bids, many otherwise well-qualified providers make a rational decision . . . they simply walk away.

Over time, like IRS regulations, Federal Acquisition Regulations have grown not only in volume, but in complexity. Figuring out how to "muddle though" the procurement process is a necessary hurdle to overcome for any contractor and invariably a nightmare for the uninitiated.

Most experienced Federal contractors eventually learn how to manage the procurement process. But for the health care organization that doesn't routinely pursue

Federal contracts, the procurement process is a daunting and intimidating hurdle. The reality is that the acquisition process is a very real barrier to market entry for many of the kinds of health care providers VA would like to encourage to bid on its contracts. The single most important step VA can take to promote greater interest and participation in its health contracting opportunities is to allow more time for proposal preparation. The three to four-week window typically available for proposal preparation is simply insufficient for most organizations unfamiliar with the process, and often a struggle for those with experience.

CONTRACT OPERATIONS

VA's CBOC contracts include numerous requirements to help ensure that the contractor meets target performance levels for key measures. As a contractor, while we "moan and grown" about such requirements, we readily acknowledge they have ultimately raised our level of performance and enhance our ability to offer high quality service.

One of the characteristics generally associated with the overall improvements in quality and outcomes in the VA since the early 1990s is the almost obsessive-like focus on the achievement of target performance measures. Part of the transformation of the VA from a system of last resort to a provider of choice has been the successful cultural transformation to an organization that established target performance measures and then aggressively and consistently monitored performance at local, VISN-wide and national levels. Another key element of the VA's success is the development, application and deployment of the Veterans Information System Technology Architecture (VISTA), it's version of the electronic medical record. In our opinion, the emphasis on performance measures and the deployment of an electronic medical record systemwide, are probably the two most significant characteristics that account for the VA's ability to achieve the remarkable turnaround that it has over the last decade.

These practices are inextricably woven into all aspects of VA care, including contractor-operated CBOCs. For example, in most CBOC contracts, there are many key performance measures (e.g., performing specific preventative tests; access requirements; requirements for accuracy and completion of data entry into the medical record; patient satisfaction; credentialing documentation, etc.) that are routinely compared to target goals. These are aggressively monitored and carefully watched and require prompt corrective action if not achieved. Performance measures are calculated for each facility, compared within each VISN, across all VISNs, and nationally.

Having been involved with, and managing primary care operations in the private sector for over 30 years, I can unequivocally confirm the positive impact of the VA's emphasis on performance measures in the primary care setting. In our opinion, the integration of and reliance on performance measures make the quality of care in VA's primary care operations difficult to match in similar operations in the private sector.

With respect to contracted CBOCs, certain performance measures are actually greater than those for VA staffed and managed primary care operations. As an example, one key aspect of contracted CBOCs is VA's practice of linking financial incentives to the achievement of target performance measures. Most of our contracts include nominal bonuses if we significantly exceed certain performance measures, or penalties if we fail to meet minimum performance measures.

CONTRACT OVERSIGHT

The level of agency oversight embedded into most VA health care contracts is distinguishing characteristic of VA health care contracting.

For example, the parent hospital associated with a CBOC performs semi-annual safety inspections on the CBOC as well. In addition, when the parent hospital is surveyed by The Joint Commission, the accreditation survey also extends to the CBOC.

One of the ironic elements of VA health care, however, is that the level of transparency that allows the public to see some of the agency's operational deficiencies and weaknesses, is, in fact, one of the system's major strengths. While some of the same elements of transparency exist in the private health sector, the nature and depth of information that is publicly available about VA operations, whether it be through routine reports and incident-specific investigations by the Government Accountability Office (GAO) or the VA Office of the Inspector General (OIG), is unmatched in the private sector.

For example, the VA OIG has, for years, conducted regular, periodic reviews of the VA's health care operations through its Comprehensive Assessment Program

(CAP) reports. These reports are similar to an internal audit of program operations and identify both strengths and weakness. They are scheduled so that every VAMC is reviewed every couple years. Until recently, CAP reports included evaluation of selected aspects of both VA and contract CBOCs under the jurisdiction of a particular VAMC.

In response to legislative language from last year VA,[1] the OIG began a new series of inspections specifically for CBOCs to provide a systematic examination of these clinics on a routine, periodic basis, much in the same way as medical centers are reviewed under the CAP.[2] Two of ACS' clinics in Indiana were among the first CBOCs in the country subject to this new type of inspection by the OIG. The OIG made eight recommendations about our clinics in particular, some of which involved elements of operations that we, as the contractor are responsible for, while other recommendations were for VA management. The recommendations have since been adopted and the issues resolved.

The key point here is that as a VA CBOC contractor, we ultimately operate in a fishbowl unlike comparable operations in the private sector. Once completed, the OIG reports are available on the VA's web site and to the public at large through the internet. We note that the same degree of scrutiny exists for any element of VA operations subject to review by the OIG. Both VA and its contractors know that their operations are subject to a degree of transparency that most providers in the private sector simply never have to worry about. While most large health care systems in the private sector conduct routine internal audits similar to those performed by the VA, for the most part they remain "internal" upon completion, and any results or findings, unsubstantiated or not, remain hidden from public view. By contrast, the VA's version of internal audits are routinely made public. I might add that the OIG inspection of our clinics recently were the most thorough of any we have experienced. While the prospect of undergoing any type of operational audit or inspection by an unrelated party can be intimidating, the prospect of going through that and having the results available for the world to see cannot help but instill a greater sense of discipline that helps ensure the achievement of target performance measures.

We believe that the transparency of program operations through these various levels of oversight, not only of our contract operations, but indeed, of all aspects of VA health care, is a tremendous strength of the VA health care system as it forces a higher level of accountability that ultimately, is in the VA and veterans' best interests.

FUTURE CONSIDERATIONS

As the VA looks to reach more veterans in rural and remote locations, we see increasing challenges from a health care contracting standpoint. Much of the success that the VA has enjoyed over the last decade is attributable to its focus on performance measures and the use of VISTA, its electronic medical record system. Many of the demanding requirements that apply to VA facilities and for VA staff are extended to its contractors. In our experience, contractors are sometimes held to higher standards than VA facilities and staff.[3] As VA moves into rural and more remote communities with the hope of negotiating various kinds of contracts and partnerships, the burdens of the procurement process and demanding contract requirements will become potentially significant deterrents to establishing the kind of business relationships sought. VA may be forced to relax many of its existing requirements in order to recruit the number and mix of providers that it seeks in certain locations. To the extent that VA hopes to address the needs of rural veterans by different kinds of contracts with local providers, it will have to rethink some of its contracting approaches to meet them halfway.

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[1] H. Rpt. 110–775, to accompany H.R. 6599, Military Construction, Veterans Affairs and Related Agencies Appropriation Bill, Fiscal Year 2009.

[2] "Informational Report, Community Based Outpatient Clinic Cyclical Reports", Department of Veterans Affairs Office of Inspector General; Report No. 08–00623–169; July 16, 2009.

[3] As an example, a contractor awarded a contract for a new CBOC typically has anywhere from 60–90 days to begin operations after award. During that time, the contractor must typically finalize negotiation of leases, renovate or buildout anywhere from 3,000–10,000 square feet of clinical space, recruit, hire and credential as many as 25 clinical and administrative staff, undergo comprehensive background checks, conduct exhaustive training and certification on VISTA and related IT security provisions, and pass multiple state, local and VA facility inspections. In general, completion of these startup tasks is a requirement of every CBOC contract. To the best of our knowledge, VA would have a very difficult time meeting the same kind of CBOC startup requirements as it imposes upon contractors.

SUMMARY

The VA has engineered a remarkable transformation over the last decade to become a national model of high quality care through its emphasis on performance measures and the use of an electronic medical record. Those practices extend to most of its contractors and force them to operate with the same set of performance and quality expectations. Contracts, when justified through a make-or-buy analysis, represent a legitimate approach to provide care when and where such services are not available in a VA facility by VA employees. While the system is now considered among the nations' best, reports of clinical problems or quality issues nevertheless continue to be uncovered as others are resolved. That deficiencies remain as visible and transparent as they do is, in fact, a major strength of the system, one that leads to quicker resolution and a level of accountability that is not seen in the private sector. The demanding practices that have improved performance and outcomes within VA over time, however, will be burdensome for rural and remote providers and may require a rethinking of VA's contracting strategies.

Thank you again for the opportunity to share our thoughts about VA contracts for health care. We want to acknowledge the extraordinary level of support we receive from the VA staff and management at the parent facilities of our CBOCs: the VA Northern Indiana Health Care System in Marion, Indiana; the Richard A. Roudebush VA Medical Center in Indianapolis; the VA Pittsburgh Health Care System, and Memphis VA Health Care System. It is a privilege to work with these professionals and an honor to serve the veteran population. I would be pleased to answer any questions.

Ambulatory Care Solutions

Marion, Indiana

Company Briefing

Prepared by Ambulatory Care Solutions, LLC

Background

- Headquartered in Marion, Indiana
- Ambucare Clinic: First walk-in, urgent care clinic in state of Indiana in 1980
- Able Ambulance: Provides VA Northern Indiana Healthcare System with BLS Transportation Services for its patients
- John L. Earnest, CEO: Responsible for opening over 50 walk-in clinics east of the Mississippi River in past business relationships
- Ambulatory Care Solutions, LLC (***ACS***) created in 2004 by principals of Ambucare Clinic and Able Ambulance specifically to provide services to veterans in VA's Community Based Outpatient Clinics (CBOCs) in Indiana and surrounding states
- ***ACS*** awarded contract for the South Bend, Indiana CBOC in October, 2004
- ***ACS*** awarded contract for the Terre Haute, Indiana CBOC in April 2006
- ***ACS*** awarded contract for the Bloomington, Indiana CBOC in May 2006
- ***ACS*** awarded contract for the Goshen, Indiana CBOC in July 2008
- ***ACS*** awarded contract for the Belmont County, Ohio CBOC in December 2008
- ***ACS*** awarded contract for the Jonesboro, Arkansas CBOC in April 2009

ACS Senior Management

John L. Earnest, Partner

John L. Earnest is the President and Chief Executive Officer (CEO) of ***ACS***. As the most senior officer of the company, he has overall responsibility for all aspects of all CBOC operations. His primary responsibilities include provider recruitment and veteran relations. He will become involved in CBOC contract management when necessary. Mr. Earnest's reputation for a "hands on" approach has allowed ***ACS*** to provide the VA the necessary corporate support to ensure a successfully run CBOC. As the full-time, on-site South Bend CBOC Clinic Administrator for the first year of operation after ***ACS*** won its first CBOC contract in 2004, Mr. Earnest learned first-hand how to manage virtually every aspect of the daily operations of a CBOC. Very few competitors have a CEO who has actually served as a CBOC Clinic Administrator and gotten his hands "dirty" by understanding all of the intricate details that go into making a CBOC run smoothly as Mr. Earnest. Mr. Earnest received his Bachelor of Science in Education from Marion College (now Indiana Wesleyan University), Marion, Indiana in 1967. He continued his education by receiving a Masters Degree in Education from Indiana University in 1973.

John R. (Rich) Earnest, Partner

John R. (Rich) Earnest is the Vice President, Treasurer and CIO of ***ACS***. His primary responsibilities include information technology, facilities management, marketing, and business development. Mr. Earnest has been a member of ***ACS*** Management Team through various ventures since 2002. Mr. Earnest acts as a liaison between the CBOCs and their respective VA hospitals, which provides for smoother implementation of new projects and the resolution of IT and facilities problems that may arise. Mr. Earnest received a Bachelor of Science in Industrial Technology in 1998 from Purdue University, West Lafayette, Indiana. He continued his education by receiving a Bachelors of Science in Business Information Systems in April of 2007 from Indiana Wesleyan University. Mr. Earnest is currently studying to obtain a Masters in Business Administration with a focus in Health Care Administration at Indiana Wesleyan University, Marion, Indiana.

ACS Senior Management (con't.)

Angela K. Dale, Partner

Angela K. Dale is the Vice President, Secretary and COO for ***ACS***. Ms. Dale has been a member of ***ACS*** Management Team through various ventures since 1996. Ms. Dale's responsibilities include all facets of human resources, office policies and procedures, and HIPAA compliance. Her ability to develop a cohesive, yet independent team of clinic administrators and staff has led to low rates of turnover in the clinics she has managed. One of her newest corporate responsibilities has been to help local Clinic Administrators replicate ***ACS'*** unique "brand" within all of our clinics. One of the reasons we believe we have been successful is that we take the time to teach management and staff about ***ACS'*** commitment to an operating philosophy that seeks to "**put veterans first**". Ms. Dale received her Bachelors in Business Administration in April of 2009 from Indiana Wesleyan University. She is also a Certified Professional Coder, which is awarded by the American Academy of Professional Coders.

Chijioke Kalu, MD

Dr. Chijioke Kalu is the Medical Director for ***ACS***. He has been with ***ACS*** since April of 2006 and also serves as Medical Director and Physician for the Bloomington CBOC. Dr Kalu attended Medical School at the Antigua School of Medicine and completed his residency in family practice at Erie County Medical Center in Buffalo New York. Upon completing his residency, he served as a Geriatric Fellow at Ball Memorial Hospital in Muncie, Indiana. After working in the Indiana Department of Corrections for 6 years as Medical Director, he joined ***ACS***.

Jerry E. Jones

Jerry Jones is the Vice President and CFO for ***ACS***. His primary responsibilities are cash flow management, financial analysis, and banking liaison. A veteran himself, his career includes 4 years in the US Army where he was stationed in Germany and France. Upon leaving the Army, Mr. Jones started working in the banking industry. He spent 35 years with First National Bank/Bank One/Salin Bank and retired in June of 2003. After retiring, Mr. Jones joined ***ACS***.

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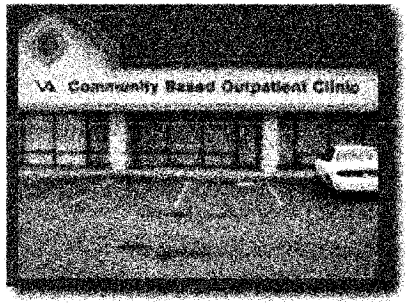
South Bend CBOC

- Counties in South Bend CBOC Service Area:
  - Fulton, IN
  - LaPorte, IN
  - Marshall, IN
  - Pulaski, IN
  - St. Joseph, IN
  - Stark, IN
  - Berrien, MI
  - Cass, MI
  - St. Joseph, MI
  - Van Buren, MI
- Parent Hospital: VA Northern Indiana Health Care System (Marion and Fort Wayne, Indiana)
- South Bend CBOC had been operational since 2001 under several predecessor contracts
- Under prior contractor, South Bend CBOC enrollments had grown to approximately 10,500 veterans
- Popularity of program led to rapid growth and difficulty accommodating demand
- Operational challenges led to enrollee dissatisfaction accompanied by significant declines in enrollment

- Contract put up for re-bid in February, 2004; awarded to ***ACS*** in August of 2004
- ***ACS*** arranged for larger facilities; assumed control of operations in October of 2004
- Starting with approximately 6,500 enrollees in October of 2004, ***ACS*** moved to restore confidence of veterans and VA in South Bend CBOC operations, gradually building enrollments back up to approximately 7600 as of April of 2009

Terre Haute CBOC

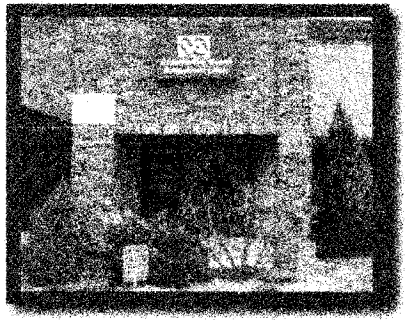
- Counties in Terre Haute CBOC Service Area:
  - Clark, IL
  - Crawford, IL
  - Edgar, IL
  - Clay, IN
  - Greene, IN
  - Parke, IN
  - Putnam, IN
  - Sullivan, IN
  - Vermillion, IN
  - Vigo, IN



- Parent Hospital: Richard L. Roudebush VAMC (Indianapolis, Indiana)
- Terre Haute CBOC had been operational since 2001 under several predecessor contracts
- Contract put up for re-bid in December, 2005; awarded to ***ACS*** in February, 2006
- ***ACS*** took control of operations in April, 2006
- Enrollment as of April, 2006: 3,842 patients
- Enrollment as of April, 2009: 4,000 patients (maximum-4,400 patients)

Bloomington CBOC

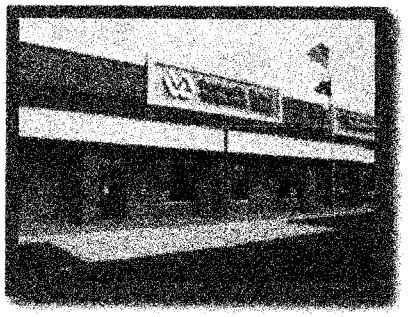
- Counties in Bloomington CBOC Service Area:
  - Bartholomew, IN
  - Brown, IN
  - Greene, IN
  - Lawrence, IN
  - Monroe, IN
  - Morgan, IN
  - Owen, IN



- Parent Hospital: Richard L. Roudebush VAMC (Indianapolis, Indiana)
- Bloomington CBOC had been operational since 2001 under several predecessor contracts
- Contract put up for re-bid in December, 2005; awarded to ***ACS*** in March of 2006
- ***ACS*** assumed responsibility for operations in May, 2006
- Enrollment as of May, 2006: 3,407 patients
- Enrollment as of April, 2009: 4000 patients (maximum 4, 400 patients)

Goshen CBOC

- Counties in Goshen CBOC Service Area:
  - Elkhart, IN
  - Kosciusko, IN
  - LaGrange, IN
  - Noble, IN



- Parent Hospital: VA Northern Indiana Health Care System (Marion and Fort Wayne, Indiana)
- The Goshen CBOC was a new contract to extend access to care to veterans in Northern Indiana.
- Contract was put out for bid in March 2008; awarded to ***ACS*** in July of 2008. The opening date was October 1, 2008.
- ***ACS*** completely renovated space previously held by a retail establishment. The buildout consisted of a 5000 sq. ft clinic with new equipment and furnishings.
- Enrollment as of July, 2009: 2500 patients (maximum 2500 patients first year)

Belmont County CBOC

- The Belmont County CBOC Service Area is only defined as any area in which the Pittsburgh VA directly services. This is roughly a 10 county area distributed over both Ohio and Pennsylvania
- Parent Hospital: Pittsburgh VAMC (Pittsburgh, PA)
- Belmont County CBOC had been operational since 1999 under another contractor
- Contract put up for re-bid in August of 2008; awarded to ***ACS*** in December of 2008
- ***ACS*** assumed responsibility for operations in March of 2009
- Enrollment as of March, 2009: 5400 patients
- Enrollment as of April, 2009: 5500 patients (maximum 6000 patients)

Jonesboro CBOC

- Counties in Goshen CBOC Service Area:
  - Craighead, AR
  - Poinsett, AR
  - Crittenden, AR
  - Greene, AR
- Parent Hospital: Memphis VAMC (Memphis, TN)
- Jonesboro CBOC had been operational since 1999 under another contractor
- Contract put up for re-bid in December of 2008; awarded to ***ACS*** in April of 2009
- ***ACS*** assumed responsibility for operations in June of 2009
- Enrollment as of June, 2009: 2850 patients (Maximum 2950)

Ambulatory Care Solutions, LLC — Company Briefing

Did you know?

- ***ACS*** currently sees over 125,000 patient visits in its facilities annually?
- ***ACS*** provides services for all new patients within seven days?
- ***ACS*** currently provides services to over 25,000 enrolled veterans in CBOCs in Indiana, Ohio, and Arkansas?
- ***ACS*** service areas of awarded contracts collectively include 30 counties in Indiana, 10 counties in Ohio, and 4 counties and Arkansas?
- ***ACS*** employs over 150 employees at all of its facilities?
- ***ACS*** provides primary care services with over 29 primary care providers?
- ***ACS*** senior management is present at all facilities on a monthly basis?
- ***ACS*** clinics provide primary care, lab, x-ray, telecrinal, telehealth, and mental health support services?

Prepared by Ambulatory Care Solutions, LLC

Chairman AKAKA. Thank you very much, Mr. Earnest.

Mr. McClain, how do you respond to Ms. Curtis's comments about the problems that Project HERO has creating a large enough network in rural areas?

Mr. MCCLAIN. Mr. Chairman, I will be glad to comment on that. Obviously Ms. Curtis has a tremendous amount of experience in the VA and in Boise, which is a very rural area. Many of her comments, I think, were directed at the fact that some of this care must be sent outside the VA, and most of it should be kept inside VA.

That certainly is an issue that this Committee has addressed and other committees have addressed and VA talks about considerably inside; and I know that funding has been provided over the years to do just that—to do more treatment inside.

So, we are simply talking about care that for whatever reason VA has decided to send outside its walls that they cannot handle either because of access issues or because the specialty does not exist inside the VA walls.

From what I have learned of the start of Project HERO and Humana Veterans there were issues with the network, and indeed, issues in rural areas. In fact, we have pretty much the same issues anyone else does.

I believe that Senator Tester stated that in one large geographic region there was one provider in his area.

Well, Humana runs into the same problem. If the providers are not there, we certainly cannot contract with them. But we have increased our network now in the four VISNs to where we have over 27,000 providers in our network.

There are patches and holes in that, which we are trying to fill right now. But for the most part we believe that we provide a very good experience for the veteran who is referred to outside care by VA in a rural setting.

Chairman AKAKA. Ms. Curtis, do you have any further comments on that?

Ms. CURTIS. Yes. I am one of those mental health providers that Senator Tester spoke about. Again I mentioned that I live only five miles away from the VA, and Project HERO attempted to obtain my services for the project.

I felt that, first off, it would be a conflict of interest obviously for me, and second off, I felt that they would be much much better served within the VA to eliminate fragmentation of treatment that might occur with outside providers.

Speaking of the highly rural areas, our Vet Center just recently initiated a mobile vet clinic for those mental health needs of veterans throughout our extensive rural network.

We also have several CBOCs and our mental health providers will actually go to those CBOCs to provide the health care. We also have mental health tele-health so that they can provide the treatment such as in Salmon. Actually we have a CBOC in Salmon, which is like 4 hours away from Boise. We have the mental health treatment capabilities within the VA practically with the mobile clinics and the tele-help.

Chairman AKAKA. This question is for Mr. Earnest and Mr. McClain. Has the VA asked your organizations to verify that you are complying with VA quality and performance measures? Will you please describe the level of VA's oversight?

Mr. Earnest.

Mr. EARNEST. Thank you, Mr. Chairman.

With regard to the VA oversight in the contracts that we presently have, we work very closely with the local hospital. In terms of performance measures, we even go to the point where we are proactive.

We pull identified performance measures every other week to see how we are scoring and if we are having any problems with those performance measures. Then, in addition, we work closely with the parent hospitals to make sure that those performance measures are met.

We have biweekly meetings in-house and we have monthly meetings with each one of the hospitals that we serve.

Chairman AKAKA. Mr. McClain.

Mr. MCCLAIN. Thank you, Mr. Chairman.

In Project HERO there are quite a few contract requirements and metrics that Humana Veterans must meet. One of them is the fact that our providers, the medical care providers, are all credentialed. That may or may not be the case in the normal fee-based referral out in the community. But in our case we go through an extensive credentialing process.

As far as VA oversight is concerned, VA actually comes out and audits our credential files on a regular basis. In fact, they were just at our office about 3 weeks ago to conduct their audit and found no deficiencies in our credentialing system.

Also we have a very active quality management oversight committee that includes VA representation. So, whenever there is a potential quality indicator—in other words some issue that arises, and this includes a peer review type of process—it will actually go to these committees for resolution. If any remedial action is required, we, in conjunction with our VA partner, would recommend that remedial action.

Chairman AKAKA. This question is for all of the panelists. From your perspectives, how can VA improve its contracting process? Project HERO had a difficult time getting off the ground so let us hear from Mr. McClain first.

Mr. MCCLAIN. Mr. Chairman, yes, it did have a difficult time. I think part of it was the short ramp-up time that we had. The contract was actually awarded, I believe, in early October 2007 and went online January 2, 2008. So, that is a little less than a 3-month period.

In order to implement in such a large geographic area with so many providers needed, that was probably too short of a time and therefore the network was lacking initially.

As I said, that has been corrected. But, I think that more collaboration with the contractor to determine exactly what an adequate ramp-up time should be, so that when you go live everything is lined-up for the veteran and the veteran is the one who gets the benefit of the contracted services.

Chairman AKAKA. Ms. Curtis.

Ms. CURTIS. The VA could best improve contract services by going back to Congress's intent, only for emergent services that VA is unable to provide.

If the VA were given the staffing that we need or the space—which sometimes that is the issue—then we would not be required to buy down the wait list. And that is basically what has happened at Boise. We wanted to get our colonoscopy wait list reduced. Instead of building another suite for colonoscopies, we bought it down through contract services. That is really unnecessary.

Chairman AKAKA. Ms. Shahani.

Ms. SHAHANI. As I mentioned, our VA contract is performance-based and monitoring of quality, timeliness, and customer service has been very good.

There was a question about the IG report and the IG audit. I think it is very good that VA finally put a billing audit in place.

It was conducted first in 2005, and currently we are undergoing another audit based on an independent third party contracted by the VA.

The initial issue with the IG report, if I may, Mr. Chairman, was a difference in contract language interpretation. Once VA brought this to our attention, what we did was we really sat down with VA and the contracting office—both the program office and contracting office. We went through the issues and we both resolved them mutually. Once everybody was on the same page—because there is an inherent difference between using Medicare for treatment guidelines versus a disability program—so, once we were able to resolve those issues and define the differences, QTC offered a payment to VA to reimburse them. This was even before the IG got involved.

Since then QTC has reimbursed the monies, and basically we have ongoing quality process improvement based on our billing and audit standards. So, I am glad to hear Mr. Mayes say that they are going to do it twice a year now.

The other thing that I would recommend is to involve the contractor every time they update the VA examination protocols. Our physicians and experts basically conduct the C&P examinations on a regular basis. They have developed expertise, and I know there is a partnership between VBA and VHA in updating these protocols. But we too would like to play a role in it because we have a lot of lessons learned that we would like to share with them.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you.

Mr. Earnest, please.

Mr. EARNEST. Thank you, Mr. Chairman.

One of the points that we heard when we first started contracting with the VA was the slogan, "One VA." We have six different contracts. We have four different hospitals, and those four different hospitals interpret those contracts in different ways. So, the point I am making here is that we need to learn to be consistent.

I also echo what was mentioned earlier. There needs to be stronger communication between the VA and its contractors. Whether we are talking about changes in the way that physical examinations are made or the ways that the contract is being interpreted, those are things that we feel just need to be happening.

The last point I will make is that we are facing these four regional offices for contracting.

I believe just the opposite works. Local communication makes a big difference. If I know that I can meet with my contracting officer—whether I drive to Indianapolis or I drive to Fort Wayne—it is a lot easier than having to worry about meeting with my contractor in Washington, DC, or wherever those four offices are.

It is potentially a much closer relationship with the people that you do business with on a daily basis.

Chairman AKAKA. Thank you.

This question is for Ms. Curtis. In your written testimony you point out that OMB has directed Federal agencies to reduce their reliance on contractors. Are you aware of any instances in which VA has failed to fill vacancies, laid off workers, or otherwise reduce staff in favor of contracting out services?

Ms. CURTIS. I am not aware of any reduction of staff at my facility based on contracting out, but it appears that there is a perception that contracting out may be quicker and easier than actually putting the staff in place at our facility.

However, the contracting out, as far as I am concerned, is just a stopgap method to take care of this wait list that we talked about. The much better way to treat our veterans in a facility that truly understands their unique needs is by hiring the staff, providing education that they require—the credentialing, the privileging—all as if we were one VA I guess you would say.

Thank you.

Chairman AKAKA. Ms. Curtis, are the problems with the Project HERO you describe in your testimony limited only to Boise, Idaho?

Ms. CURTIS. No, they are not. This is happening throughout the Nation and particularly in the rural treatment areas.

Chairman AKAKA. As a follow-up, was the system for providing care outside VA better before Project HERO?

Ms. CURTIS. I feel it was. We have personal relationships with our contractors. Personal relationships really go a long way in helping the veteran feel at ease when he is receiving treatment there.

I believe it also helped us keep their medical record from being as fragmented. We would quite quickly get the results of any procedures that were done and scan it into our medical records so when the veteran came back to their primary care provider, they had the complete information.

I worry with that second layer between the provider and the VA with the records going through Humana that something might get dropped. It would be much easier for that to happen and then the veteran's care would definitely suffer.

Thank you.

Chairman AKAKA. Thank you very much for appearing here today.

Contracts for services will almost certainly be part of VA's efforts to provide care to veterans. But the VA is obligated to ensure that the Nation's veterans receive the best health care services in any setting regardless of whether such services are provided at a hospital, a contract clinic, or during a compensation and pension exam. VA must also be a good steward of the taxpayers dollars and obtain these services at a reasonable cost.

We wanted this hearing to try to flush out what needed to be done to improve the whole program. So, my final question to all four of you—and you may or may not wish to comment—is do you have any recommendations or even suggestions to make about this process to us, that is Congress, as well as the VA?

Ms. CURTIS. Mr. Chairman, obviously my suggestion would be to bring the treatment back to the VA in-house.

Chairman AKAKA. Thank you.

Mr. McClain.

Mr. MCCLAIN. Mr. Chairman, I do have some suggestions I would like to, if I could provide those after the hearing.

Chairman AKAKA. We would appreciate that, yes.

[The additional information requested during the hearing follows:]

HUMANA VETERANS HEALTH CARE SERVICES, INC.,
October 7, 2009.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

HVHS #09–0051

DEAR MR. CHAIRMAN: This letter is a follow-up to the hearing on September 30, 2009, entitled "VA's Contracts for Health Services," and is in response to your solicitation of recommendations from the second panel to improve outcomes in contracted health care and to fully realize the benefits and efficiencies of Project HERO. We appreciate the opportunity to provide this input. I want to emphasize at this point that Humana Veterans and the VHA Program Management Office (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.

1. *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 while continually improving the model.

We believe Congress desired such a demonstration process with the ultimate goal of improved service to veterans who are referred to community providers for evaluation or care. VA has 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 five-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.

2. *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 from 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.

3. *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.

4. *VA should track metrics in their legacy Fee-based process.* One of the most significant lessons learned from Project HERO to date is the importance of metrics in the delivery of quality healthcare both inside and outside of VA. The Project HERO contractor has developed a data repository called the Data Mart to assist in tracking the metrics required for quality healthcare and facilitating analysis of that data. These metrics include:

a. Length of time until appointment is scheduled.

b. Length of time from receipt of an authorization for care until the veteran is seen by the network provider.

c. Length of time until the network provider's written consult report is returned to VA.

Implementing similar metrics would greatly enhance fee-based care in VHA.

5. *The HERO Model of personalized services for veterans should be implemented at each VHA Fee office.* The HERO Model as developed by Humana Veterans in partnership with VA includes the following services to veteran patients:

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) from 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 five 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 15 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.

Humana Veterans stands ready to assist the Committee and VA in every way possible to ensure enhanced quality and personalized healthcare services to our Na-

tion's heroes. Please do not hesitate to contact me directly at 502–301–6984 or *tmcclain2@Humana.com* if there are any questions.

Sincerely,

TIM S. MCCLAIN,
President & CEO.

Chairman AKAKA. Ms. Shahani.

Ms. SHAHANI. Mr. Chairman, I would recommend that there is a role for contractors. I believe there is a role for contractors and there is also a role for the VHA. There are a lot of veterans and active duty servicemembers who need to be serviced in remote areas and in areas where VHA is unable to staff and provide the services for our veterans and active-duty servicemembers, especially for compensation and pension services. I suggest that the Committee maybe invite us so that we can share with you what we have done to actually bring the physician to the active duty servicemember and to the veteran, and how we've improved access, thereby improving services to them.

So, we are here if you need us to elaborate on things and discuss things better. We would like to share with you. And at the end of the day, I believe we are all here to service our veterans and active-duty servicemembers.

So, anything we can do please let us know.

Chairman AKAKA. Mr. Earnest.

Mr. EARNEST. Thank you again, Mr. Chairman.

The two points I would make is, number 1, management. We feel it is very strong within our organization, that is, management. There is management at all levels and there should be management of the contractor by the VA.

We welcome that management. In terms of an OIG inspection, we cannot correct it if we do not know about it. We want to know those things so that we can be an even better contractor for the VA.

The second point I would make is communication. We said that two or three times already this morning. It is important that the two entities—whether it is the VA or the contractor or the employees group—communicate with one another so that we all know what the agenda is and we can all better serve our veterans.

Chairman AKAKA. Thank you very much. You are right that all of us here are trying to do the best we can to provide for our veterans. That is the bottom line. So, I thank you so much for what you are doing and look forward to continuing to work with you.

This hearing is adjourned.

[Whereupon, at 11:36 a.m., the Committee was adjourned.]

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