HEARING ON VA CONTRACTS FOR HEALTH SERVICES

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WEDNESDAY, SEPTEMBER 30, 2009

United States Senate,
Committee on Veterans' Affairs,
Washington, D.C.

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 CHAIRMAN AKAKA

Chairman Akaka. Good morning. Please be seated. The hearing of the Senate Committee on Veterans' Affairs hearing 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 these services. 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 that 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 our witnesses on our first panel. Joseph Williams, Acting Deputy Undersecretary for Health Operations and Management of the Veterans' Health Administration, will lead our discussion of 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. Jan Frye, Deputy Assistant Secretary for Acquisition, Logistic, and Construction.

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

But before we begin with your testimonies, I want to call on Senator Tester for this opening remarks.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Thank you, Mr. Chairman.

I guess I made it just in time. I wish I could have heard your comments but I want to thank you very very much for having this hearing on this important issue, and as always I want to thank the folks who are here to testify and give their perspective for being here also. I appreciate it very 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 and 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 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 eight-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 that are the lynchpin of VA's health care system.

And I am particularly concerned that reports about the 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 worry 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 but 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 of 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 and 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, 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, OFFICE ACQUISITION, LOGISTICS, AND CONSTRUCTION

Mr. Williams. Mr. Chairman, ranking members, 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 considered sending patients to another VA medical center. If contracting of services is 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 affiliates. VA academic affiliates provide a large portion of contract 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 standards for VA contracted care when services are provided outside of the VA facility is more complex but VA contracted care when services are provided would be reflected in the language that allows for the industry standard 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

five-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 C&P 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 to 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 1550 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 but 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 of 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 the opportunity. My colleagues and I are prepared to answer your questions.

[The prepared statement of Mr. Williams follows:]

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.

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 and I just want to mention to you to feel free to call on them as we move along with the questions. But 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. But over the last two and half years, we have

developed a financial data warehouse of information at our Veterans' Service Center and 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 it 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, 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 that go 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.

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

Chairman Akaka. Mr. Williams, on overcharges for CBOC contract care, a recent report for the Inspector General found that VA had been charged by a clinic contractor for over 4000 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 and make sure that 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 two 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 needs 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 system 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, no, I do not have the 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 able, to be competent when they step in the examine room.

Mr. Williams. Mr. Baker will address that.

Mr. Baker. We do have a certification program that was begun approximately a year and half ago for compensation and pension exam providers. It was designed through our compensation and pension examine 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. 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. It 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 that they require two or three exams at least to complete the review of their body systems for the disability exams that has 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, exams 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 saying, and you just 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 examiner be properly credentialed and be familiar and understand how to apply that.

Senator Tester. I am sure the VA, and I may not be

sure on this. You have to help me. 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 be VBA and internally to VHA.

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, both 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.

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 claims. To that extent, we have standards in place for quality and we are taking that off in VHA and with our contract providers.

Senator Tester. I did not track 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. Okay. My time is up. Thank you, Mr. Chairman.

Chairman Akaka. Thank you very much, Senator Tester.

Le me call on Senator Begich for your questions.

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

First is more of a general question on the HERO versus the traditional fee-basis program. I know you are two years, two and a half 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 that sense it is on a five-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. A potential of five 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, 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 on 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. 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 total cost of non-VA care, purchased care. 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 and 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 number 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 a feel 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 schedules.

The IG considered that as an error on our part and 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 expect that 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. And have you at any point in the last, you know, three or four year--I think this was a four-year study. I cannot remember exactly. But 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 has asked 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. Okay. 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 18 and a half percent. It is still tens of millions of dollars.

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

So I guess I would urge you in your process of reevaluating your procedures that that is part of it, 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 over billings 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 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. Okay, and 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 overpaids are just VA mistakes on the proper report paperwork and that everyone should have been paid?

Mr. Baker. I am saying that the IG report when they said there were overpayments, they are saying that VA inappropriately applied either its fee schedule or Medicare schedule that should have applied for what was billed to us, and that that was not a fault of the vendor but rather an internal fault of the 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. --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 for any opening statement and your questions.

OPENING STATEMENT OF SENATOR BURR

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:]

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Senator Burr. Mr. Baker, I will direct this at you. Well, let me go to what Senator Begich was on. Does the VA track error rates in fee for service health care provided? 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 the 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 contracting care from fee-based. In contracting care, you can stipulate in the contract that they have to report their error experience.

Mr. Baker. 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 that 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 time or two times or three times that they went outside the system at the direction of the VA?

Mr. Baker. If that information is not available and 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 indicates 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 contacted care both are considered an integral part of our treatment of veteran and that we do have monitoring systems in place and quality performance standards 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, geographic accessibility are the principal issues.

Senator Burr. Okay. 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 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 across the country to meet many other specialty care needs in our universities and our medical schools.

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 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. But I hope you understand that we are at 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 statistics, 25 percent of enrollees in the VA seek all their care within the VA. 75 percent treat some combination of care with 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 you are going to have to seek a hundred percent of your 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 always necessarily the most cost effective or

the most effective from the standpoint treatment.

I thank the chairman allowing me to go over.

Chairman Akaka. Thank you very much, Senator Burr.

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

Senator Burris. Thank you, Mr. Chairman.

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

Chairman Akaka. It will be included in the record.

[The prepared statement of Senator Burris follows:]

/ COMMITTEE INSERT

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 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. --the cost per patient for the HERO patient is something over $1000 for medical care, outpatient medical care. The fee, gross fee per patient is over $4200.

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

In terms of Delta Dental, the fee average cost of $1600 and the average was for HERO is approximately $1500. So approximate a hundred dollars 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 contract services are necessary for 20 percent of the compensation and pension medical examinations? 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 worked, collaborated with VHA and we put contracts in place that covered those jurisdictions.

Senator Burris. So why cannot the VA hire for 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 which is in close proximity to Washington in Alexandria? Why is the VA unable to directly hire examiners in our Nation's Capital? 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 service members 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, 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 find neurologists, where we might be looking at audiology, 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 35 days. That is one of our marks that we have been looking at. So it is a rate.

We, 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 two 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, the 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. But from time to time, depending on the rate, the 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 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, VA is creating I understand 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 towards 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 Price Waterhouse Cooper 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 and 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 and getting the contracts out and making sure that they are properly monitored and oversight was conducted.

And 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 organizations 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 make sure and monitor the quality of the contracts, do the audits, make sure that they are compliant with all the regulations, make sure they follow up on the COTRs which is the contracting technical representative who are the program folks who are 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 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 over reliance 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 29th, 2009, each agency subject to the CFO Act, the Chief Financial Officer Act, must conduct a pilot under which we 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 that 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 over billing. 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 over billing in the first place. The OIG then came in following the audit that we had implemented and identified or confirmed some of that over billing.

Following that, we sent a bill of collection to QTC and they did repay the government for the over billing. They

not only repaid the over billing for the term of the initial audit that we have 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 award terms, the way the contract was structured were 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 the 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.

But I would mention that they did not receive award terms for all of the years of the contract. It was a base year and four option years. They only received award terms for three out of those five 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 clarify. I assume we go through Mr. Williams but I think you are probably going to refer it to Mr. Mayes because it was a question you 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. Okay. 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, so what you are tracking is performance and timeliness of the exams 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. 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. The customer satisfaction, 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 it 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 and we then are constantly in communication with vendors with respect to any findings that we are discovering 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.

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 rate? I am talking about VA versus contractor.

Mr. Mayes. Appeal with the decision?

Senator Tester. Appeal with the examine. 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, or Mr. Williams, either one, 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 then us to make the legal determination.

So we are looking at the quality of 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, 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 that would be very much appreciated. 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.

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, it sounded like you did an internal audit. When was that done?

Mr. Mayes. We did an internal audit. It was for the period June of 2005 to May of 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 and we will continue that in the future. These are some of the lessons we are learning.

Senator Begich. The process on 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 that it is not, I understand your internal audit but that they have a certain responsibility or change in their procedures or a change 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 separate and apart from obviously 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. Will you have within the contracts that are about to go out, will have some procedure or some process that clearly stipulates, 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, 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 did it. He put you on the spot. So I get to ask it but can you provide, and again I know customer satisfaction, I know when I was the chair of the Alaska Student Loan Corporation for seven years, we did an analysis every quarter of our customers in determining the satisfaction of the quality of work, processing, all the stuff that goes with it.

It also drove everything from how long they hung on the phone call 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 is 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 a 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. Then overall satisfaction with the services provided.

Senator Begich. Let me end you there and say I would love to see if there is an annual 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.

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.

And that is, if someone is 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 we 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.

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 the records contain protected information. 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?

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.

Under contract management, in the 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, and performance, and quality of their programs.

Contracting officers support program managers by putting contracts in place and that is the tool that the program managers 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 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.

Every soon we will begin training program and project managers. We train our contracting officer technical representatives, and we have also implemented an intern program and we are recruiting 30 interns per year.

This is a three-year program. It is very robust. We have just recently brought on our second group of 30. So at the end of three years, we will have approximately a hundred 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 some 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 to, 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, New Jersey. 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, New Jersey. 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, Maryland. The strategy there was that it is easier to have people drive against traffic. Instead of coming to Washington, DC, stay in Frederick, Maryland, 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 down in Austin, Texas. 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 operational capable in July of 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 requirement 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 in the Ritz Carlton near the Pentagon, invited 120 vendors in, 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 the program 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 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 dismissed this panel, this is not really a question for you but I would like you to take back to VA my concern about the situation in American Samoa and the Philippines.

I want you 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 will be helpful, 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 it better than you on what needs to be done. But we certainly want be a part of that. Whatever we can help with legislatively even we would like to do that.

Again thank you very much first panel.

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 members 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 our staff shortages our capacity has not kept up with the need.

I did hear testimony earlier about C&Ps 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, 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 that interacts very closely with CPRS so that really improves the quality of the exams.

But back to the other contracting out 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 for over two 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 and 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 was a similar push to use HERO over our own fee-basis providers during the last two 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 was 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 of 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 was 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 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:]

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 as Human 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 of his or her shoulder until the veteran returns to the primary care VA doctor.

During the journey the veteran has received various personalized services that comprise the HERO model as I stated in my written statement.

The employees of Humana Veterans are proud of what they 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 partner.

For example, although not required in the written contract, we have implemented a data repository, called our data mark. 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 develop 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 demonstrations 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 out-based care. The fee office decides whether to send a preauthorized veteran to regular fee-based care or to the

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 for VA to 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:]

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 service members.

The VA contract ensures high-quality services through both performance requirements and performance metrics. Performance requirements include using licensed and credentialed physicians and other specialties 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, 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 standard is 38 days on average from receipt of exam request to 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 standard is the minimum of 92 percent as complete, 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 has 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 six 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, 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 extraordinary role our VBA customer has displayed in achieving the objectives.

We are dedicated to serving the veterans and active duty service members, 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:]

Chairman Akaka. Thank you very much, Mr. Shahani. Mr. Earnest.

STATEMENT OF JOHN L. EARNEST, PRESIDENT AND CHIEF EXECUTIVE OFFICER, AMBULATORY CARE SOLUTIONS

Mr. Earnest. Thank you, Mr. Chairman, and 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 two 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 is 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 are some things that we can 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, Goshen, Indiana, and also St. Clairsville, Ohio, and Jonesboro, Arkansas. We have over 25,000 enrollees in the six clinics.

We are a small business, and with us being a small business 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, 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, quarterly basis, and we are graded on these performance measures.

All of our contracts have incentives or penalties involved with them if we hit those 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:]

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 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, and 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 this Project HERO and Humana Veterans, there were issues with the network and indeed issues in rural area. 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 that 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 our 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 four 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, and 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 then 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 three 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; and if any remedial action is required, we, in conjunction with VA partner, would recommend that remedial action.

Chairman Akaka. This question is for all of the panelists, the witnesses. From your perspectives, how can

VA improve its contracting process from your perspective? 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 of 2007 and went online January 2, 2008. So that is a little less than a three-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 the adequate ramp up time would 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, and 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 program office and contracting office.

We went through the issues and we both resolved it mutually. Once everybody was on the same page because there is an inherent difference between using Medicare for treatment guidelines and 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 back once we were both on the same page. This was before even the IG got involved.

Since then QTC has reimbursed the moneys, and basically

we have ongoing quality process improvement based on our billing and audit standards. So I am glad to hear Mr. Mayes said 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.

Mr. Earnest. Thank you, Mr. Chairman.

One of the points that we heard when you first started contracting with the VA was the acronym, synonym, whatever, One VA. We have six different contracts. We have four different hospitals, and those four different hospitals interpreter those contacts 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 am just the opposite. Local communication. 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 I have to worry about meeting with my contractor in Washington, DC, or wherever those four offices are.

It is just a much closer relationship that you can have 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 get the results quite quickly of any procedures that were done and scan it into our medical records so the providers, 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, 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, in 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.

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 service members who need to be serviced in remote areas and in areas where VHA is unable to staff and provide the services for the veterans and active-duty service members, especially for compensation and pension services, 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 service member and to the veteran and to improve 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 service members.

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 one, management. We feel it is very strong within our organization, that is, management. There is management at on 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.]