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VA Contracts for Health Services

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Introduction

Good morning. My name is John L. Earnest and I am the President and Chief Executive Officer of Ambulatory Care Solutions, LLC (ACS). ACS is a small business headquartered in Marion, Indiana. We currently operate six Community Based Outpatient Clinics (CBOCs) under contract to the Department of Veterans Affairs (VA).

We appreciate the invitation to offer comments to the committee about VA health care contracts. While VA contracts for almost every different type of health care service imaginable, my comments this morning will be limited primarily to our experience under the VA's CBOC initiative.

Senior management of ACS has been involved in the operation of emergency care, urgent care and primary care clinics in the private sector for over 30 years. In previous positions prior to ACS, I was responsible for the re¬cruitment and staffing of 85 hospital emergency department contracts and was involved in the start-up of over 50 walk-in medical facilities east of the Mississippi, including the first urgent care center in the state of Indiana in 1980.

Following enactment of P.L. 104-262, the Veterans Health Care Eligibility Reform Act of 1996, the legislation that gave the VA additional contracting flexibility, we began to notice the VA's expansion into community based primary care. My colleagues and I believed that our operational experience was directly relevant to the kind of care sought for veterans under CBOC contracts and that we were well-positioned to respond to this rapidly growing demand. Ambulatory Care

Solutions was established in 2004 specifically to provide primary care for veterans through the CBOC initiative.

ACS was awarded its first CBOC contract in South Bend, Indiana in August of 2004. Since then we have added contracts in Terre Haute, Indiana in February, 2006; Bloomington, Indiana, in March, 2006 and Goshen, Indiana in July, 2008. We were awarded our first CBOC contract outside of Indiana in St. Clairsville, Ohio in December of 2008, and the contract for Jonesboro, Arkansas in April of this year. At the present time, through our six CBOC contracts in three states, we serve over 25,000 veteran enrollees and provide in excess of 125,000 patient visits annually.

ACS is a small business whose management philosophy is characterized by a "hands-on" approach. We emphasize on-site presence by senior management throughout the life of our CBOC contracts. We maintain a conservative managed-growth strategy that ensures we devote the time necessary to bring each new CBOC contract online smoothly. While ACS now looks carefully at most CBOC opportunities that come up, we have historically declined to pursue any new opportunity until we are confident that our existing contracts are running smoothly. We have actually withdrawn one of our bids after submission, as a result of simultaneous, but unanticipated changes in multiple procurement schedules, rather than proceed with a project where changes threatened our ability to deliver as promised. While this was a difficult management decision, it was one that we felt was ultimately in the best interests of veterans, the VA and ACS.

Although ACS is not veteran owned, we place a priority on recruiting and hiring vets at both the corporate level and each of our delivery sites. For example, ACS' Chief Financial Officer, Jerry Jones, is an Army veteran.

There are several key points I wish to emphasize in my testimony today about VA contracts for health services. They are as follows:

• To Contract or Not Contract? That is the Question…Under the right circumstances, contracting for a CBOC may be the best solution for veterans and the VA in a given market area.

• The Procurement Process is a Barrier to Entry--The procurement process is complex and serves as a significant barrier to entry for many qualified firms.

• Contract Operations--While we find the requirements of VA CBOC contracts to be very demanding, we believe that they ultimately serve to significantly enhance overall performance and quality of care.

• Contract Oversight--The potential for public oversight of most VA contracts is significant. In many respects, the degree of transparency now available to the public for CBOCs operated both by VA and by contract is unmatched in the private sector.

• Future Considerations--Improved access to veterans in rural and more remote areas through partnerships or relationships with local providers may call for the VA to relax some of the

demanding contractual requirements that have been largely responsible for the agency's successful transformation over the last decade.

To Contract or Not to Contract? That is the question....

One of the age old questions in every federal agency responsible for providing some type of service is the perennial "make or buy" dilemma. This remains a complex question for the VA in particular, as the longstanding tradition of having medical care for veterans provided primarily by VA employees in VA facilities has been put to a challenge by economic rules that guide such decisions.

It was a much easier decision to make in the "old days"...when most health care for veterans was provided in inpatient settings. But as the demand for care shifted to outpatient settings, the economics changed as well. While we readily acknowledge and respect the preference on the part of many veterans and veterans' organizations for the privilege of being treated by VA staff in VA facilities, we know of no formula that incorporates the powerful emotional attachment to "our facilities" and "our staff" into the "make or buy" decision model. In general, we think that most constituencies, including veterans, Veterans Services Organizations, as well as Congress, ultimately recognize the need for, and benefits of contracting to supplement the VA's system of care in appropriate circumstances, but there remain pockets of strong opposition based on principle...if not economics.

It is much too easy to suggest that only VA itself can provide the quality of care and respect that veterans deserve, or, that, conversely, no contractor is capable of demonstrating the same degree of respect, concern or quality as veterans receive in VA facilities.

We think the most appropriate response to the "make or buy" question is what's best for the local veteran population in question on a case-by-case basis. So while the decision to have the VA staff and operate a CBOC in one location may be the right decision, the best solution in another location may indeed be a contractor-operated CBOC. Neither the VA nor its contractors have a perpetual "lock" on delivering high quality care. Issues can, and do arise from time to time, regardless of the source of care or location; the most important consideration is to put in place the management controls to continuously review and monitor performance so that it remains at or above target levels. VA does this for its own services, and those protocols extend to their contracted services as well.

VA utilizes a comprehensive evaluation process to make such make-or-buy decisions, as described in VHA Handbook 1001.6, Planning and Activating Community Based Outpatient Clinics. ACS carefully evaluates those opportunities where VA has decided that the best alternative is to acquire the services via contract.

The Procurement Process is a Barrier to Market Entry

The federal contracting and procurement process is a tremendously complex, highly bureaucratic, intimidating process that is always changing...and not for the feint-of-heart. That is a lesson we learned the "old fashioned" way. ACS submitted multiple bids over several years before we successfully entered this market. We have become more adept at the process since then. It wasn't easy then…and it remains a challenge to this day.

As an example, the last Request for Proposal (RFP) we bid on for a CBOC was 170 pages long, not including the hundreds of pages of internal VA documents cited in the RFP itself, or most of the Federal Acquisition Regulation (FAR) or VA Acquisition Regulation (VAAR) clauses cited "by reference". The latest printed version of the FAR is 1,969 pages and the VAAR, a "quick read" by comparison, turns in at a mere 370 pages. To its credit, part 873 of VA's own regulations provide "Simplified Acquisition Procedures for Health care Resources", although they are to be used "in conjunction with" the FAR and VAAR. When the level of complexity is combined with the limited time available to prepare bids, many otherwise well-qualified providers make a rational decision...they simply walk away.

Over time, like IRS regulations, Federal Acquisition Regulations have grown not only in volume, but in complexity. Figuring out how to "muddle though" the procurement process is a necessary hurdle to overcome for any contractor and invariably a nightmare for the uninitiated.

Most experienced federal contractors eventually learn how to manage the procurement process. But for the health care organization that doesn't routinely pursue federal contracts, the procurement process is a daunting and intimidating hurdle. The reality is that the acquisition process is a very real barrier to market entry for many of the kinds of health care providers VA would like to encourage to bid on its contracts. The single most important step VA can take to promote greater interest and participation in its health contracting opportunities is to allow more time for proposal preparation. The three to four-week window typically available for proposal preparation is simply insufficient for most organizations unfamiliar with the process, and often a struggle for those with experience.

Contract Operations

VA's CBOC contracts include numerous requirements to help ensure that the contractor meets target performance levels for key measures. As a contractor, while we "moan and grown" about such requirements, we readily acknowledge they have ultimately raised our level of performance and enhance our ability to offer high quality service.

One of the characteristics generally associated with the overall improvements in quality and outcomes in the VA since the early 1990s is the almost obsessive-like focus on the achievement of target performance measures. Part of the transformation of the VA from a system of last resort to a provider of choice has been the successful cultural transformation to an organization that established target performance measures and then aggressively and consistently monitored performance at local, VISN-wide and national levels. Another key element of the VA's success is the development, application and deployment of the Veterans Information System Technology Architecture (VISTA), it's version of the electronic medical record. In our opinion, the emphasis on performance measures and the deployment of an electronic medical record systemwide, are

probably the two most significant characteristics that account for the VA's ability to achieve the remarkable turnaround that it has over the last decade.

These practices are inextricably woven into all aspects of VA care, including contractor-operated CBOCs. For example, in most CBOC contracts, there are many key performance measures (e.g., performing specific preventative tests; access requirements; requirements for accuracy and completion of data entry into the medical record; patient satisfaction; credentialing documentation, etc.) that are routinely compared to target goals. These are aggressively monitored and carefully watched and require prompt corrective action if not achieved. Performance measures are calculated for each facility, compared within each VISN, across all VISNs, and nationally.

Having been involved with, and managing primary care operations in the private sector for over 30 years, I can unequivocally confirm the positive impact of the VA's emphasis on performance measures in the primary care setting. In our opinion, the integration of and reliance on performance measures make the quality of care in VA's primary care operations difficult to match in similar operations in the private sector.

With respect to contracted CBOCs, certain performance measures are actually greater than those for VA staffed and managed primary care operations. As an example, one key aspect of contracted CBOCs is VA's practice of linking financial incentives to the achievement of target performance measures. Most of our contracts include nominal bonuses if we significantly exceed certain performance measures, or penalties if we fail to meet minimum performance measures.

Contract Oversight

The level of agency oversight embedded into most VA health care contracts is distinguishing characteristic of VA health care contracting.

For example, the parent hospital associated with a CBOC performs semi-annual safety inspections on the CBOC as well. In addition, when the parent hospital is surveyed by The Joint Commission, the accreditation survey also extends to the CBOC.

One of the ironic elements of VA health care, however, is that the level of transparency that allows the public to see some of the agency's operational deficiencies and weaknesses, is, in fact, one of the system's major strengths. While some of the same elements of transparency exist in the private health sector, the nature and depth of information that is publically available about VA operations, whether it be through routine reports and incident-specific investigations by the Government Accountability Office (GAO) or the VA Office of the Inspector General (OIG), is unmatched in the private sector.

For example, the VA OIG has, for years, conducted regular, periodic reviews of the VA's health care operations through its Comprehensive Assessment Program (CAP) reports. These reports are similar to an internal audit of program operations and identify both strengths and weakness. They are scheduled so that every VAMC is reviewed every couple years. Until recently, CAP

reports included evaluation of selected aspects of both VA and contract CBOCs under the jurisdiction of a particular VAMC.

In response to legislative language from last year VA , the OIG began a new series of inspections specifically for CBOCs to provide a systematic examination of these clinics on a routine, periodic basis, much in the same way as medical centers are reviewed under the CAP. Two of ACS' clinics in Indiana were among the first CBOCs in the country subject to this new type of inspection by the OIG. The OIG made eight recommendations about our clinics in particular, some of which involved elements of operations that we, as the contractor are responsible for, while other recommendations were for VA management. The recommendations have since been adopted and the issues resolved.

The key point here is that as a VA CBOC contractor, we ultimately operate in a fishbowl unlike comparable operations in the private sector. Once completed, the OIG reports are available on the VA's web site and to the public at large through the internet. We note that the same degree of scrutiny exists for any element of VA operations subject to review by the OIG. Both VA and its contractors know that their operations are subject to a degree of transparency that most providers in the private sector simply never have to worry about. While most large health care systems in the private sector conduct routine internal audits similar to those performed by the VA, for the most part they remain "internal" upon completion, and any results or findings, unsubstantiated or not, remain hidden from public view. By contrast, the VA's version of internal audits are routinely made public. I might add that the OIG inspection of our clinics recently were the most thorough of any we have experienced. While the prospect of undergoing any type of operational audit or inspection by an unrelated party can be intimidating, the prospect of going through that and having the results available for the world to see cannot help but instill a greater sense of discipline that helps ensure the achievement of target performance measures.

We believe that the transparency of program operations through these various levels of oversight, not only of our contract operations, but indeed, of all aspects of VA health care, is a tremendous strength of the VA health care system as it forces a higher level of accountability that ultimately, is in the VA and veterans' best interests.

Future Considerations

As the VA looks to reach more veterans in rural and remote locations, we see increasing challenges from a health care contracting standpoint. Much of the success that the VA has enjoyed over the last decade is attributable to its focus on performance measures and the use of VISTA, its electronic medical record system. Many of the demanding requirements that apply to VA facilities and for VA staff are extended to its contractors. In our experience, contractors are sometimes held to higher standards than VA facilities and staff. As VA moves into rural and more remote communities with the hope of negotiating various kinds of contracts and partnerships, the burdens of the procurement process and demanding contract requirements will become potentially significant deterrents to establishing the kind of business relationships sought. VA may be forced to relax many of its existing requirements in order to recruit the number and mix of providers that it seeks in certain locations. To the extent that VA hopes to

address the needs of rural veterans by different kinds of contracts with local providers, it will have to rethink some of its contracting approaches to meet them halfway.

Summary

The VA has engineered a remarkable transformation over the last decade to become a national model of high quality care through its emphasis on performance measures and the use of an electronic medical record. Those practices extend to most of its contractors and force them to operate with the same set of performance and quality expectations. Contracts, when justified through a make-or-buy analysis, represent a legitimate approach to provide care when and where such services are not available in a VA facility by VA employees. While the system is now considered among the nations' best, reports of clinical problems or quality issues nevertheless continue to be uncovered as others are resolved. That deficiencies remain as visible and transparent as they do is, in fact, a major strength of the system, one that leads to quicker resolution and a level of accountability that is not seen in the private sector. The demanding practices that have improved performance and outcomes within VA over time, however, will be burdensome for rural and remote providers and may require a rethinking of VA's contracting strategies.

Thank you again for the opportunity to share our thoughts about VA contracts for health care. We want to acknowledge the extraordinary level of support we receive from the VA staff and management at the parent facilities of our CBOCs: the VA Northern Indiana Health Care System in Marion, Indiana; the Richard A. Roudebush VA Medical Center in Indianapolis; the VA Pittsburgh Health Care System, and Memphis VA Health Care System. It is a privilege to work with these professionals and an honor to serve the veteran population. I would be pleased to answer any questions.