MARY A. CURTIS, APRN, BC, PSYCHIATRIC CLINICAL NURSE SPECIALIST, AND CLINICAL APPLICATION COORDINATOR, BOISE VA MEDICAL CENTER

STATEMENT BY

MARY A. CURTIS, APRN, BC
PSYCHIATRIC CLINICAL NURSE SPECIALIST
AND CLINICAL APPLICATION COORDINATOR
BOISE VA MEDICAL CENTER
BOISE, IDAHO

ON BEHALF OF
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON VA CONTRACTS FOR HEALTH CARE

SEPTEMBER 30, 2009

Chairman and Members of the Committee:

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

Overutilization of Contract Care

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

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

Health care contracts are one of many tools available to the VA to increase access for rural veterans and address other gaps in care. The Veterans Health Administration (VHA) Office of

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

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

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

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

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

Fee Basis Care

Many medical center directors justify the increased use of costly fee basis care in recent years as the only means of providing care to veterans in a timely manner and accessing specialty care, in the face of physician recruitment and retention problems. As a result, management may end up paying more on a fee basis that it would cost to attract providers to the VA workforce.

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

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

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

Project HERO

This pilot project is supposed to manage VA contract care more effectively than the VA can manage it with its own staff and infrastructure. Project HERO essentially injects for profit contractors into the contract care process as the intermediary between the VA and veterans who may need to be referred outside the VA for care.
Both the implementation and ongoing operations of Project HERO have been conducted largely behind closed doors. Based on the limited objective data available and observations by our members in facilities participating in HERO, it appears that HERO has little or no "value added": HERO contractors are simply not doing a better job managing contract care than the VA.

In fact, there are early signs that the insertion of another layer in the contract care process and the use of for profit care coordinators have delayed care, left veterans confused and dissatisfied, required some veterans to travel further and depleted VA's internal capacity to directly manage fee basis care (in addition to the larger budget problems resulting from increased spending on contract care, as already discussed.)
It also appears that HERO contract care referrals cost the VA more than fee basis referrals it makes directly. The HERO program pays its network providers less than they would be paid if they were contracting directly with the VA under its fee basis program. Then, it appears that HERO contractors bills the VA at a higher rate and also tacks on hefty referral fees.

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

We have seen no justification for awarding contracts to Humana and Delta for all four pilot VISNs; the use of a different contractor in each VISN would have yielded useful comparative information and may have better served the unique needs of each area.
Similarly, despite AFGE's request, HERO has provided no justification for renewing the Humana

and Dental contracts of the second and third years. (The third pilot project year begins on October 1, 2009; HERO has the option to renew these contracts for a total of five years.)

Among the critical questions that remain unanswered:

- How much is Project HERO costing the VA in terms of program administration at the national, VISN and local facility levels? The Nation magazine (April 9, 2008 issue) described HERO as a $915 million program, but AFGE is not aware of any specific appropriations for the program.
- What does HERO cost the VA compared to fee care arranged directly by the VA? What do HERO contractors charge the VA for different medical services, and how are referral fees set?
- What share of VA provided care and VA fee basis care has been shifted to HERO? Last year, HERO program officials reported to the media that the program covered 30% of all veterans enrolled with the VA. At a September 23rd briefing for AFGE, HERO program staff told AFGE that "HERO contract use is less than 2% of VA unique outpatients receiving medical care."
- What criteria were used to award Humana and Delta Dental an exclusive contract for all 4 pilot VISNs? What criteria were used to renew these contracts year?

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

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

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

Conclusion

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

More specifically, through Project HERO, the VA has outsourced a function that has traditionally been performed in-house: determining whether a veteran should receive medical care from an outside provider rather than the VA. Second, the VA has outsourced the operation of a large number of CBOCs; the IG recently identified a number of problems associated with contract

outpatient clinics (Report Number 09-01446-226, 9/23/2009). Third, Congress continues to authorize the use of contractors to conduct C&P exams for disability claims, despite mixed evidence of using the benefits of using a for profit contractor rather than providing the VA with additional staff and training to perform more of these exams in-house.

AFGE also recommends joint labor-management training on the VA fee program. Informed staff working on the front lines of VA health care can play a valuable oversight role in assessing whether fee basis determinations are properly justified and authorized.
Finally, Congress should withhold funding for the fourth and fifth option years of Project HERO and any further expansion of the pilot pending an investigation of its actual costs, its impact on health care quality and access, and on VA's internal capacity to manage contract care. We commend Senate appropriators for including HERO oversight language in the FY 2010 VA appropriations bill report (Senate Report 111-040), and urge this Committee to ensure that the VA complies with the requirement to report to Congress by October 30, 2009.

Thank you for the opportunity to testify on this issue.