Veterans Health Care: Project HERO Implementation

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Summary

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

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

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

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

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

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Introduction and Overview of the VA Health Care System

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

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

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

Generally, veterans have a choice of where they receive their care. While some veterans rely more heavily on care through the VA health care system, the majority of veterans not enrolled in the VA health care system receive care through the private sector which is financed by Medicare, private health insurance, or the military health care system.[4] VHA is a direct health care provider, but it is not generally a third-party payer of care. For veterans who are eligible to receive care through the VA health care system, the decision on whether to receive care from the VA may depend on a

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

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

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

[4] Congressional Budget Office, *Quality Initiatives Undertaken by the Veterans Health Administration*, August 2009, p. 5. Veterans who are military retirees have access to TRICARE, the Department of Defense health care plan. For more information, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by (name redacted), and CRS Report RS22402, *Increases in Tricare Costs: Background and Options for Congress*, by (name redacted).

variety of factors, such as out-of-pocket costs, distance, and waiting times for appointments, among other things.[5]

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

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

Methods Used to Provide Care Outside the VA Health Care System

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

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

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

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

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

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

health care network and through non-VA providers is an issue for policymakers, as well as for the VHA and other stakeholders.

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

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

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

1. Has Project HERO enhanced the existing fee basis care program?[10]

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

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

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

[8] CRS Report R40737, *Veterans Medical Care: FY2010 Appropriations*, by (name redacted).

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

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

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

Project Healthcare Effectiveness through Resource Optimization (Project HERO)

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

> The conferees support expeditious action by the Department to implement care management strategies that have proven valuable in the broader public and private sectors. It is essential that care purchased for enrollees from private sector providers be secured in a cost effective manner, in a way that complements the larger Veterans Health Administration system of care, and preserves an important agency interest, such as sustaining a partnership with university affiliates. In that interest, the VHA shall establish, through competitive award by the end of calendar year 2006, at least three managed care demonstration programs designed to satisfy a set of health system objectives related to arranging and managing care.[12]

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

- provide as much care for veterans within the VHA system as possible;

- when necessary, efficiently refer veterans to high-quality community-based care;

- improve exchange of information between VA and community providers;

- increase veteran patient satisfaction;

- foster high-quality care and patient safety;

- sustain partnership with university affiliates; and

- secure an accountable evaluation of demonstration results.

To implement this demonstration VHA selected four Veterans Integrated Service Networks (VISNs),[14] based on data that showed that these four networks had the highest expenditures for

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

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

[14] The VA's health care system is organized into 21 geographically defined Veterans Integrated Service Networks (VISNs). Although policies and guidelines are developed at VA headquarters to be applied throughout the VA health care system, management authority for basic decision making and budgetary responsibilities is delegated to the VISNs (see Kenneth Kizer, John Demakis, and John Feussner, "Reinventing VA Health Care: Systematizing Quality (continued...)

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

Overview of Fee Basis Care[17]

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

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

Figure 1. Non-VA Outpatient Fee Basis Care, Pre-Authorization Phase
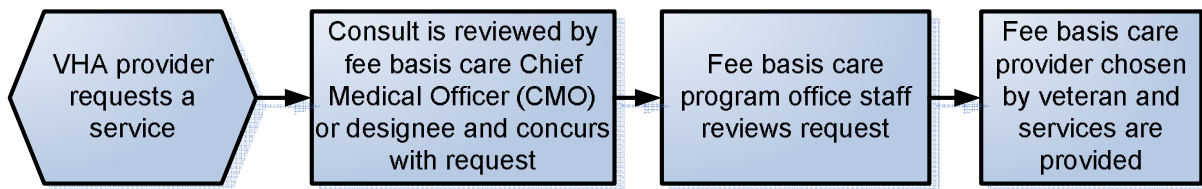
Source: Congressional Research Service graphic based on Department of Veterans Affairs, Office of Inspector General, *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program*, Report No. 08-02901-185, Washington, DC, August 23, 2009, p. 20, and Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System, April 22, 2009.

(...continued)

Improvement and Quality Innovation." *Medical Care*. vol. 38, no. 6 (June 2000), Suppl 1:I7-16.

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

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

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

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

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

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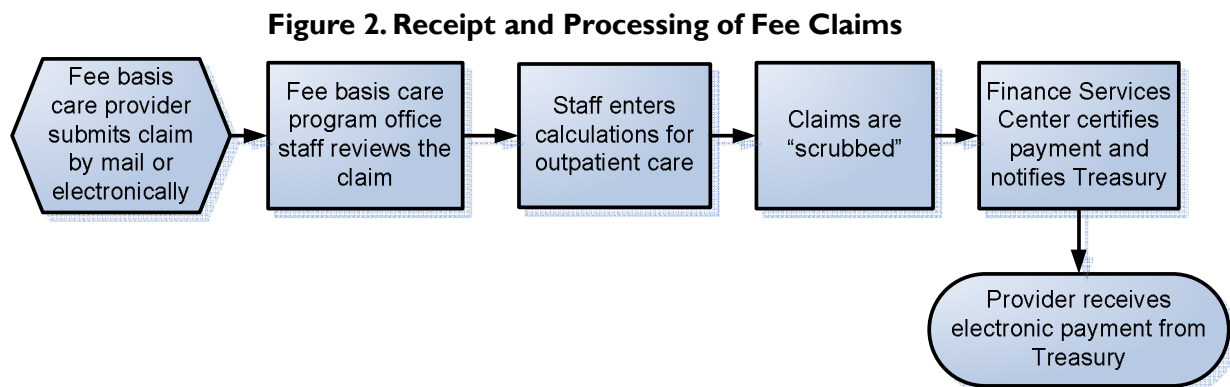
Figure 2. Receipt and Processing of Fee Claims

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

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

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

How Project HERO Works Compared to Fee Basis Care

Under Project HERO, veterans receive primary care at their local VA health care facility, as is the case under the regular fee basis care program. Similarly, if a VA health care provider determines that the specific medical expertise or technology is not readily available at the local facility then

the provider requests that the service be obtained from a non-VA provider. The consult request is reviewed by the fee basis care CMO and, if the CMO concurs, the request proceeds to the fee basis care program office. At this point in the process, the fee basis care program office determines whether to send the referral to Project HERO (based on whether the services are provided within a reasonable distance under Project HERO), and if so sends an authorization for care to HVHS.[19]

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

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

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

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

Figure 3. Authorization Process For Non-VA Care Under Project HERO
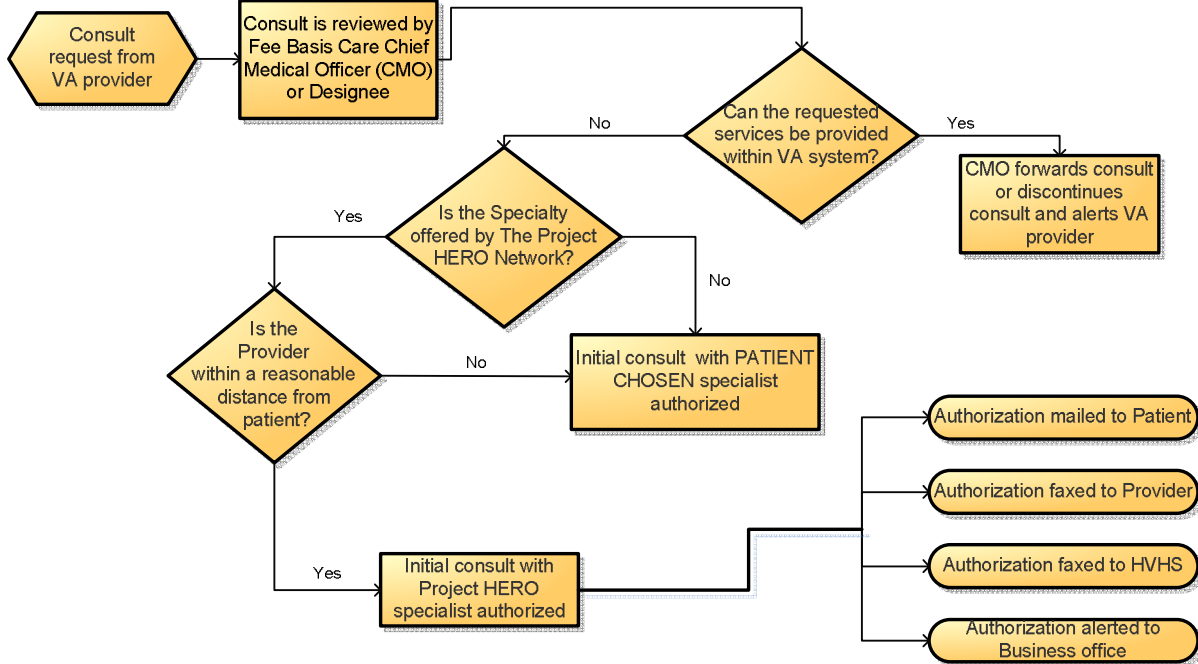
Source: : Congressional Research Service graphic based on Department of Veterans Affairs, Office of Inspector General, Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program, Report No. 08-02901-185, Washington, DC, August 23, 2009, p. 20, and Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System.

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

Figure 4. Receipt and Processing of Fee Claims Under Project HERO
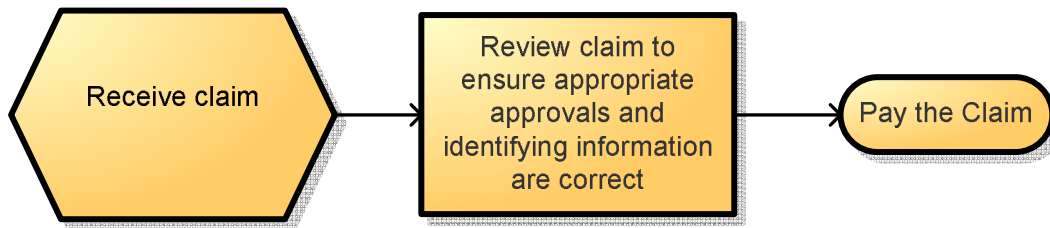
Source: Congressional Research Service graphic based on Project HERO briefing by Alvin S. Haynes Jr., M.D., Chief Medical Officer, Fee Basis Program, Bay Pines VA Health Care System, April 22, 2009.

Project HERO Implementation

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

Utilization

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

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

(Total Patients in VISNs 8,16, 20, and 23)
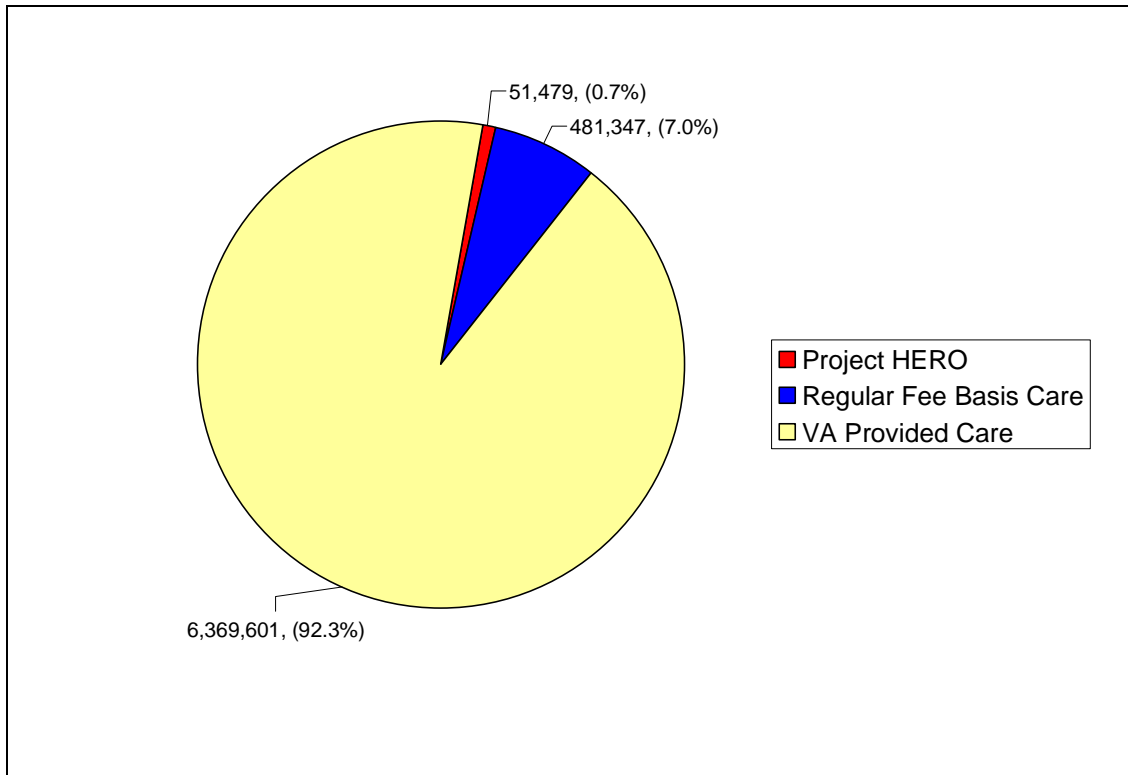
51,479, (0.7%)

481,347, (7.0%)

■ Project HERO
■ Regular Fee Basis Care
□ VA Provided Care

6,369,601, (92.3%)

Source: Chart prepared by Congressional Research Service based on data from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office.

Notes: Outpatient care provided from January 1, 2008 thru September 30, 2009.

Figure 6. Number and Percent Distribution of Outpatient Visits

(Total Outpatient Visits in VISNs 8,16, 20, and 23)
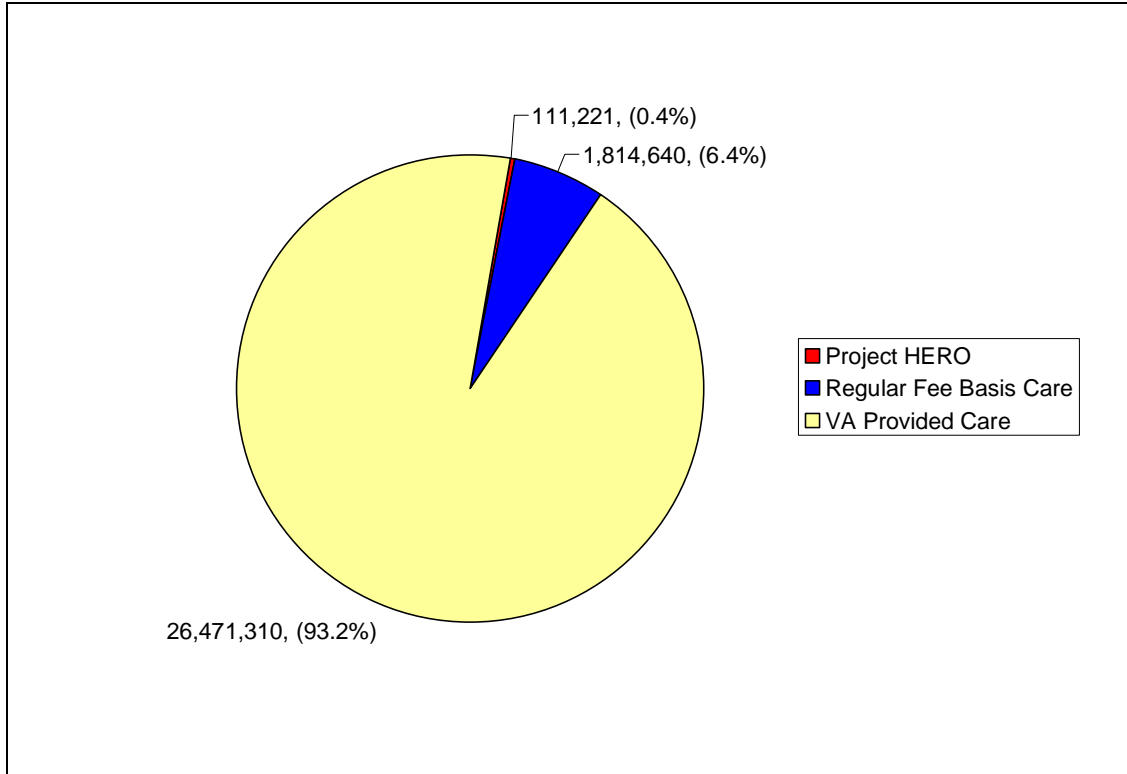
111,221, (0.4%)

1,814,640, (6.4%)

- Project HERO
- Regular Fee Basis Care
- VA Provided Care

26,471,310, (93.2%)

Source: : Chart prepared by Congressional Research Service based on data from Department of Veterans Affairs, Veterans Health Administration, Chief Business Office.

Notes: Outpatient visits from January 1, 2008 thru September 30, 2009.

Quality of Care

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

Project HERO is used to provide quality health care when needed health care services are not available. "Not available" means that services are not offered at all, are not available within a reasonable amount of time, or are not available within a reasonable distance, within the VA health care system. Currently, VHA policy has established a goal of scheduling appointments within 30 days of the desired appointment but not more than four months beyond the desired appointment date. When a specific appointment date is not requested, VHA policy requires the scheduler to use

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

the next available appointment. Furthermore, VHA policy also requires that all appointment requests, including consult referrals to a specialist, must be acted on by the medical facility within seven days.[22] The contract requires that HVHS report the following metrics as part of the standard evaluation of access to care: number of times care is provided within 30 days, number of appointments scheduled within 5 days, and number of patients seen within 20 minutes of appointment time. HVHS reports that in August 2009, 93.9 % of appointments were scheduled within five days of receipt of authorization, and that the average time it took to schedule an appointment was 2.1 business days once an authorization was received. HVHS also claims that in the same month 88.2% of the referred patients were seen by a HVHS provider within 30 days.[23]

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

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

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

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

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

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

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

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

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

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

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

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

Costs and Reimbursements

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

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

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

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

[30] Ibid, pp.9-11.

[31] 38 C.F.R. § 17.56. Reimbursement under the 75th percentile methodology is determined for each VA medical facility (continued...)

VHA pays HVHS a value added fee that ranges from $30.75 to $48.09 per claim, and these amounts vary by VISN and type of service (see **Table 1**).

Table 1. Value Added Fee Amounts, FY2009

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

Source: Humana Veterans Healthcare Services.

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

Table 2. Project HERO Payments Including Value Added Fees

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

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

Notes:

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

(...continued)

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

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

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

Discussion

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

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

Has Project HERO Enhanced the Fee Basis Care Program?

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

The current Project HERO demonstration could be categorized as an enhancement of the regular fee basis care program. The demonstration pilot provides a single point of contact for those veterans who are authorized to receive care outside the VA health care system. Under the demonstration HVHS works with the veterans and the HVHS network provider in scheduling the

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

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

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

appointment. It also allows the veteran to seek care from a credentialed provider, as well as facilitates the transfer of medical information, thereby assisting with care coordination. Furthermore, under Project HERO, VA does not have the responsibility for paying for care provided outside the system directly to non-VA providers. However, VA pays for these services through value added fees to HVHS.

Are There Lessons to Be Learned from the Pilot Program?

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

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

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

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

(3) Education is key to a successful functioning network.

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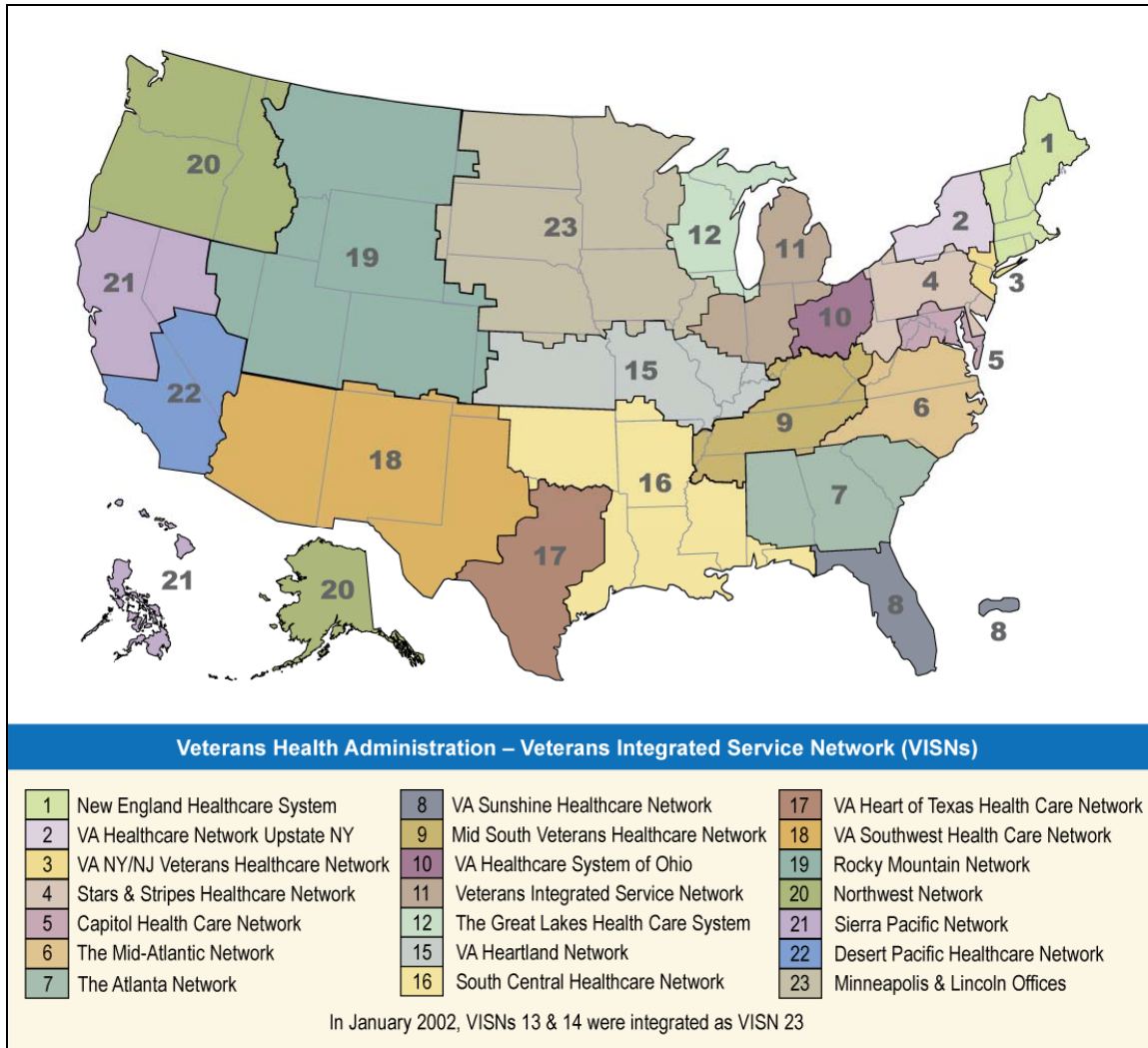
(4) The project has yielded information that could be applied to the existing regular fee basis care program.

First, without the electronic sharing of medical records between the VA health care system and non-VA providers, there are delays in the transfer of clinical information. In some instances this delay may result in a VA provider not being alerted to the need for immediate follow-up care

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

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

Appendix. Veterans Integrated Services Networks (VISNs)

Veterans Health Administration – Veterans Integrated Service Network (VISNs)

1	New England Healthcare System	8	VA Sunshine Healthcare Network	17	VA Heart of Texas Health Care Network
2	VA Healthcare Network Upstate NY	9	Mid South Veterans Healthcare Network	18	VA Southwest Health Care Network
3	VA NY/NJ Veterans Healthcare Network	10	VA Healthcare System of Ohio	19	Rocky Mountain Network
4	Stars & Stripes Healthcare Network	11	Veterans Integrated Service Network	20	Northwest Network
5	Capitol Health Care Network	12	The Great Lakes Health Care System	21	Sierra Pacific Network
6	The Mid-Atlantic Network	15	VA Heartland Network	22	Desert Pacific Healthcare Network
7	The Atlanta Network	16	South Central Healthcare Network	23	Minneapolis & Lincoln Offices

In January 2002, VISNs 13 & 14 were integrated as VISN 23

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

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