

U.S. Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)



Boston VHA Academic Affiliate Contracting Forum
Summary Report

Submitted by:

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Overview

This report is a summary of the Veterans Health Administration (VHA) VHA Academic Affiliate Forum held on Wednesday, July 18 at the Sheraton Boston Hotel in Boston, Massachusetts. Thirty-one academic affiliate representatives and twenty-eight VHA representatives participated in both plenary and breakout sessions during the day. It was the first in a series of three forums being hosted by VHA to share information with its affiliate partners.

Full plenary topics included:

- The Value and History of the VHA-Affiliate Partnership
- The Contracting Process
- The Pricing Challenge & Potential Tools
- Ask the VHA and Improvement Forum question and answer session
- The Path Forward

Breakout sessions topics included:

- Improving the Negotiating Process or Performance Metrics & Quality Assurance
- Improving the Negotiating Process or Recruitment verses Contracting
- Credentialing and Privileging
- Information Security

Action Items

- VA will review the 'per physician day rate' for use in contracts.
 - The current pay model may treat cost services as fixed price.
- VA will investigate the use of fee-basis contracts for off-site work.
 - Referrals under Directive 1703 count as a referring service.
- VA will develop a communications piece that describes who is accountable for what area in the contract issue escalation chain.
 - The document will be user friendly and minimize the use of acronyms.
- VA will provide an example of a Quality Assurance Plan to forum attendees.
- VA will provide example security clearance Standard Operating Procedures to forum attendees.
- VA will review its fringe rate policy and determine whether or not some parts of that rate that have been approved by other agencies can be used for VA.

Welcome and Opening Remarks

Mr. Norbert Doyle, Chief Procurement Officer for VHA, welcomed participants and made some brief opening remarks. He reinforced that academic Affiliates are partners of VHA in providing service to veterans, and this forum is a way to share information that will improve this partnership.

VHA and Affiliates are at a critical point in their relationship – particularly around the contracting process – and must work to formalize and improve these relationships. Although the partnership can be challenging, it is extremely valuable to VA, the Affiliate institutions, doctors, medical students and to veterans. This is especially important as these contracts are under scrutiny by the Office of Inspector General (OIG).

This is the first forum of its kind that brings VA together to work directly with its Affiliates. As such, it provides an important opportunity to understand the constraints at both institutions: different organizational structures from one Affiliate to another, various federal regulations that provide parameters for what can and can't be included in a contract and how it should be administered, and changing personnel. VHA is working to improve its internal processes, and this forum will provide valuable information that will advance those improvement efforts.

The facilitator reviewed the agenda and encouraged participants to introduce themselves before proceeding with the morning plenary topics.

Presentations and handouts have been posted at the following web site:

http://www.theambitgroup.com/vasrt/VHAfiles_Boston.php (Password: VHAfiles4U)

The Value and History of the VHA-Academic Affiliate Partnership

Dr. Judy Brannen, Clinical Director Undergraduate and Graduate Medical Education, VHA Office of Academic Affiliations (OAA)

Dr. Brannen discussed the history and value of the VHA-Academic Affiliate partnerships, the current status of medical education in VA, residency supervision and accreditation issues, and alternatives for physician staffing at VA facilities. Some key points from her presentation are noted below:

- VA is the largest provider of healthcare education in the country. Graduate Medical Education accounts for 80% of VHA's funding.
- The residency program and the innovative healthcare that is available through VA are key recruiting tools.
- There has been an increased emphasis on supervision over the past 20 years. There will be revisions to resident supervision regarding standards for telemedicine and home health in particular.
- VHA and Affiliates must work together to ensure the program maintains accreditation. VHA must pay attention to work hours of the Affiliate, for example.
- There are a variety of alternatives for physician staffing. It is important that VHA and the Affiliates work together to understand these options and choose the most appropriate vehicle for service.

Participants did not have any questions for Dr. Brannen following the presentation but were encouraged to contact her with questions or concerns afterwards at Judy.Brannen@va.gov.

The Contracting Process

Charlie Benmark, Director, Medical Sharing/Affiliate (MSO), VHA Office of Procurement & Logistics (P&LO)

Ms. Benmark provided an overview of the contracting process, including recent changes and planned improvements to that process. She also reviewed the organizational structure at VHA that supports this process. Key points from that presentation are included below.

- P&LO is organized by regions – Service Area Organizations (SAO) East, Central and West. Each SAO has a Network Contracting Office (NCO) led by a Network Contracting Manager (NCM), which is focused on contract activities in that network. This new organizational structure has a performance-driven culture, is effective in using resources, reduces redundancies in business processes, and enables employee development and increasing competency.
- Affiliates are encouraged to get to know their NCM. This person is the first level of authority in the network that can meet with you and resolve problems after you have engaged your Contracting Officer.
- VA increased contracting staff as a result of an independent study that indicated more staffing resources were needed. Due to this increase in staff, VA started a formal training course for its contracting workforce. Three courses have been conducted to date.
- The Medical Sharing Office (MSO) provides administrative oversight and initiates policy guidance related to Affiliate contracts. They serve as the principal negotiators for Affiliate sole source contracts over \$500k. The office has made a concerted effort to partner with the Office of the Inspector General (OIG) to address their concerns about the Affiliate contracting process.
- MSO plans to deploy cross-functional training with Affiliates to address the concerns discussed today.
- Interim contracts should be used only in limited circumstances. It has been used in the past to address poor planning on the part of both Affiliates and VHA.

Participants shared the following questions and comments as a result of the presentation.

- *Who should be included in acquisition planning?*
 - **Ms. Benmark:** The acquisition planning team, at minimum, should include a clinical representative from the medical center, Chief of Staff of the medical center, Contracting Officer's Representative (COR), a representative from the center's fiscal office and quality office, the Information Security Officer (ISO), and the Contracting Officer (CO). The CO must be present during planning, as they can provide contract business advice and conduct risk assessments on the procurement. Anyone who is a stakeholder at the medical center should be involved.
- *It would be useful if VHA created a narrative or guide for activities involved in acquisition planning.*
- *We have a hard time negotiating VHA's "on-call" pricing requirement.*
 - On-call parameters are addressed in the OIG pre-negotiation review. We know this is a problem for Affiliates, and both sides need feedback on on-call requirements prior to negotiation.
 - Everything in the current Directive 1663 policy is being considered for re-write. On-call parameters and payment methodologies are among those items considered. Pricing guidance

- is being considered for the Standard Operating Procedures which provides more flexibility and can be readily changed as we evolve.
- Any kind of reimbursement methodology is a contracting issue, and the CO has authority. We have standard operating procedures that govern acquisition information and process. Pricing is very important and the documentation will be revised. Because we are in a sole-source environment, we need to be very particular about being fair and reasonable which is more challenging.
 - *Academic Affiliates are viewed as a partner, but there is a difference between a full partner and junior partner. When VHA makes a new policy, they tell us "this is how it's going to be." Affiliates would like the opportunity to comment on a policy while it's being drafted and prior to policy roll-out. We may be able to identify issues in the policy that VHA may not have thought of.*
 - *Related to negotiations, when Affiliates are negotiating a contract, we bring in the physician who provides the services into a meeting with the contracting staff so the clinical perspective is shared. This has been effective for us.*

Participants were also prompted to provide their feedback on the improvements that VHA is planning.

- *A big challenge is staff turnover in the contracting offices. We know VHA is making efforts to reduce this challenge, but we see senior level turnover every year. This has not improved.*
 - **Ms. Susan Taylor:** The national acquisition turnover rate is 7%, and VHA is in line with this rate. The Contracting Officer skill set is very much in demand across the federal government so it is difficult to retain those individuals. VHA has made great progress over the past two years to fill open vacancies – less than half remain to be filled.
 - **Mr. Doyle:** The government hiring processes takes a while (about six months) and that adds to vacancy times. VA has also improved the opportunities for promotion within the contracting career path so people can now go from intern to Senior Executive Service.
- *VHA should develop an on-line tool to show Affiliates where a contract is in the life cycle. It would be helpful to know where a contract is and what it will take to move it forward in the process.*
 - **Ms. Benmark:** VHA can provide milestone dates, plans, and acquisition schedule.
 - That information will only get us halfway there; the milestones must be met, and if they are not, it must be communicated.
- *It will be helpful to have a single point of contact in the contracting office.*
 - **Ms. Benmark:** COs are the lowest on the totem pole and are the best people to contact if there are issues. Often times, the hold-up is not them, so a higher level sometimes needs to get involved, and that is where the Network Contract Managers can assist.
- *Longer-term contracts would help Affiliates so that there is no need to renew contracts every year. Also, regarding renegotiation, it is hard for Affiliates to predict what rates will be next year, and they cannot guess an increase. Identifying budget and rate projections should be included in the process. Affiliates need guidance on the early rate increases from VHA.*
 - **Ms. Benmark:** Because we are not sure about what budgets will be for each upcoming fiscal year, we are looking at different options or clauses in contracts. There should be some kind of budget projection which would give VHA an idea on where contracts and rates are heading. This activity will be conducted during the acquisition planning stage. Economic Price Adjustment clauses are being explored for use in Affiliate sole source contracts.

Pricing Challenges

Karyn B. Rae – Director of Managed Care, Medical University of South Carolina (MUSC)

Ms. Rae presented an Affiliate perspective on how Medical University of South Carolina delivers services as an Affiliate institution. She also shared some of the challenges and opportunities associated with sole-source contracting. Some key points from her presentation are included below.

- Each academic Affiliate partner is different in terms of missions and structures, so contracting is approached differently.
- Colleges of medicine are for teaching and research, while hospitals are for patient care. Salaries can come from any of these sources.
- Department chairs are usually the decision makers.
- In some cases, contracting is centralized, but often it is not.
- Many faculty members are veterans.
- Having Affiliate status provides additional opportunities for funding and sharing resources. Affiliates are not able to do many important things without VA partnerships.
- If an Affiliate employee makes a mistake, they can get fired. If a CO makes a mistake, they go to jail. This is an important thing to keep in mind when trying to understand why decisions are made.
- The Directive 1663 adds stress for COs, and federal regulations can be very complex. Every activity and decision must be documented. Proof is always required. Medicare pricing is easy, but other elements are difficult.
- Universities do not always have clear policies. OIG can be very demanding, requiring not just data, but also related policy information. It can be particularly difficult to define costs for embedded faculty. Support staff and indirect costs are also difficult areas to document.
- VA does not pay for on-call unless the Affiliate pays for this separately.
- Workweek calculations are problematic, as the Affiliate gets stuck with 'unproductive time,' like travel and administrative time.
- The speed of the process is frustrating and knowing who you can talk to when is often a problem. For example, the Chief of Service or Chief of Staff cannot discuss the contract with the Attending, which can be challenging.
- There are positive aspects. The MSO is well staffed and knowledgeable. They have some latitude in making decisions, which is very helpful. Charlie Benmark and her team are an incredible resource.

Brian Vasbinder – Procurement Analyst, VHA Service Area Organization (SAO) East

Mr. Vasbinder presented essential information on policies and programs that guide the pricing process, including the Federal Acquisition Regulations and Directive 1663. A few key points from his presentation are included below.

- Affiliates do not need to provide certified cost and pricing data, but they do need to provide other than certified cost and pricing data. Federal Acquisition Regulation (FAR) Part 15 explains this.
- Directive 1663 require that the OIG review must happen within 20 days of OIG receiving ALL information. It is important to note that all information must be ready before the OIG review can begin.

- The most common question asked as a result of reviewing Affiliate proposals is about the basis of estimate for the final cost. The data required to adequately support a basis of estimate is included in Handout #3. Although it does not guarantee the cost will be approved, providing this level of data will help speed the process.
- Direct costs should be allowable, allocable, and reasonable. Handout #4 includes a basic collection of these costs with allocation, reasonableness, and the supporting document information for each cost element.

Following these presentations, participants asked questions and provided comments. Below is a summary of the resulting discussion.

- **Mr. Norbert Doyle:** Based on the presentations, it seems that there are 15-20 contracts with different departments at Affiliate institutions. It seems there may be a way to consolidate these contracts. In addition, if VHA had a single point of contact at the Affiliate institution, that may be more advantageous than having one for each contract.
 - **Ms. Rae:** Departments have different practice plans, which would make consolidating contracts difficult – each department is like its own separate corporation.
 - **Ms. Benmark:** VHA has been looking at ways to streamline contracts with multiple departments. One idea is to do an umbrella contract for the basic terms and conditions that will not change in each contract. This would create a master solicitation that can be updated and changed as policies change, and could be used for every new solicitation.
- *Some of our agreements have been priced to Center or Medicare and Medicaid Services (CMS). When we submitted bills, the bills were sent to a re-pricing organization, which cuts prices. Can you explain this?*
 - **Ms. Benmark:** Historically, contracts with negotiated Current Procedural Terminology (CPT) rates are processed through the Chief Business Office (CBO). These invoices are run through a Fee Basis computer program that records the workload and get processed as a fee claim through the re-pricer program instead of processing the procedure for the negotiated rate in the contract. We are working to make these two systems align so the proper price is paid, as negotiated prices are not considered by this software. This process is very complicated, but you should contact your CO if you have a payment question.
 - **Mr. Vasbinder:** VA is taking a closer look at Medicare pricing and payment at the time of service delivery. Currently, at the time of billing, the supplier is being paid at the Medicare rate, but sometimes a percentage is stripped out because not all of the services were performed at the VA institution.
- *During the recruitment of new physicians, suppliers are finding that physicians are asking for additional things as part of their employment package. For example, iPhones to keep medical records, a driver due to vision issues, scribes, an assigned mentor, etc. Is VA considering including these in its rewrite of Directive 1663 for direct costs?*
 - **Mr. Vasbinder:** These types of cost would be reviewed for allowability and reasonableness by the negotiation team during the negotiation process.
- *AMA is publishing a list of 'what to ask for in your contract.' Are these things allowable?*
 - **Mr. Vasbinder:** We will consider reasonable costs that are not explicitly prohibited and are directly associated with the contract.
- *Would VA reconsider the per physician day rate? A group of physicians are providing service to VA, but the institution may not know in advance who is going to be available to support the work, so why not develop a day rate, not for the individual physician, but for the entire group that rotates?*

- **Mr. Vasbinder:** This can be considered, but it needs to be discussed. An idea may be to come up with an allowable day rate range for the physicians.
- **Mr. Frye:** It sounds as if VA is awarding fixed price contracts but then treating them as hourly contracts by tracking hours and costs. Is that what we are doing? It seems that VA is trying to fit a cost type contract into a fixed price world – after negotiating rates and hours for a physician under Directive 1663 and issuing the contract. It doesn't seem that there is a need to monitor the hours. This is something we need to investigate further within VA. **(Action Item)**
- *If you do an off-site contract, why are you not paying on a fee basis? This is drawing out the contract process and doesn't make sense.*
 - **Ms. Benmark:** Under Fee Basis authority, referrals under Directive 1703 count as a referral service. We are going to need to look into this. **(Action Item)**
- *Is it good practice to provide coverage with intermittent physicians or are there problems with this?*
 - **Mr. Vasbinder:** It is an acceptable practice, however the Service line and Contracting Officer make the final determination of how the contract will be structured.
 - **Ms. Enchelmayer:** Just watch the credentials. That is the reason Affiliates use interims because they can go through the credential process ahead of time.
- *What mechanism is available to the Affiliates to recapture some of the costs for contract preparation (administrative costs, bid and proposal preparation, etc.)?*
 - **Mr. Vasbinder:** They can be added as a line item under additional costs. It is the same for scheduling and billing/invoicing as well.
- *If a physician is promoted or there is a change to the fringe benefit formula, can the Affiliate provide documentation to adjust the price in the option years? What does the contracting officer (CO) need to do to implement the change?*
 - **Ms. Benmark:** The CO decision and they would need to verify it, make sure it is applicable and then execute the change in a modification. Also, if the existing key personnel depart from the Affiliate and the new staff have a greater cost, you must notify the CO and ask for a modification, but make sure you have justification for the change.

VHA Café: Improving the Negotiation Process

VHA Representative: **Charlie Benmark, Charlie Benmark, Director, Medical Sharing/Affiliate (MSO), VHA Office of Procurement & Logistics (OP&L)**

Facilitator: **Pat Tallarico**

Note Taker: **Megan Dunn**

Ms. Benmark opened the session with background on the negotiation process and reviewed the associated handouts. A few key points from her opening comments are included below.

- Negotiation teams include:
 - Clinical representative (Subject Matter Expert [SME], preferably a physician)
 - CO (warranted authority to sign the contract)
 - Procurement / Price Analysts for price assessment
 - Regional Counsel (They are not required to be in the meeting, but acts as an advisor. They cannot tell a CO what they can and cannot award.)

- Office of Inspector General (OIG), (not really a part of negotiation, but can come in handy when there is a 'stalemate.' They perform a pre-negotiation review. They cannot tell a CO what they can and cannot award.)
- The negotiation team makes a business decisions by talking to Affiliates about what is allocable to that particular contract, and not the whole department. We want to use business reasonableness when negotiating. This is not an exact science, but we come to agreement on what is reasonable.
- VHA is most interested in what Affiliates used to assess the costs they are proposing.
- If support documentation is not available, one alternative is using the compensation plan and tying the plan back to the price proposal according to what is allocable.
- Ideally, the negotiation process should only take a month or less.
- An MSO Principal Negotiator holds pre-solicitation meetings with the Affiliates to give the team the opportunity to discuss the procurement process, expectations, and required documentation.
- Per the Federal Acquisition Regulation (FAR), the proposal reponse time is typically 30 days. We understand that it may be necessary to allow greater response times and during the Affiliate Kick-off meeting with the MSO Principal Negotiator and Contracting Officer, that is an issue that can be discussed.
- No one can read the Affiliate proposals aside from the negotiation team who have signed procurement integrity certificates binding them to confidentiality.
- After the VA Team pre-negotiation meeting, the team reviews the Affiliate proposal and support documentation to formulate a negotiation strategy. Negotiations can not begin until the OIG review is received by the Contracting Officer.
- The negotiation teams were established for several reasons, but one was because there are many new, inexperienced COs who needed the education on the complexities of Affiliate organization and pricing methodologies. Also, VHA saw very complex requirements with no pre-communication regarding the solicitation. In pre-negotiation phase prior to submitting the proposal documentation to OIG, we hope through communication with the Affiliate to establish acceptable support documentation prior to submitting to the OIG. This will decrease the review time and minimize inquiries from them, which can extend the timeline.
- While OIG recommendations are not binding, there may be consequences if a recommendation was not used and there are issues after award. We take these recoemendations seriously and make sure to document exactly the reasoning behind the business decision to accept or reject the recommendation.
- If we communicate early and often, we can get answers. There is always something out of someone's hands that that COs are not aware of and because of the heavy workload, COs tend not to think about it unless there is a fire. The more communication there is the better chance to be prepared and to succeed. There are multiple tools that can be used and the only system required to be updated is eCMs.
- The following people are in the contract issue escalation chain. You should feel free to go up the chain if you are not getting an appropriate response from someone. (This is not related to the negotiation process.) VHA will provide Affiliates with information on who is accountable for what in the contract issue escalation chain and will do so with minimal acronym use. **(Action Item)**
 - Contracting Officer (CO)
 - Health Care Supervisor
 - Network Contract Manager (NCM)
 - Service Area Office Director
 - Deputy Chief Procurement Officer (Susan Taylor)

- Chief Procurement Officer (Norbert Doyle)
- VHA would like to host webinars or other education venues to share details about the new negotiation process with Affiliates. One webinar could cover the roles and responsibilities of the organizational chart provided.

Following these opening remarks, participants were invited to ask questions and provide additional comments.

- *Affiliates need a framework for different scenarios based on the information we have on what VA considers legitimate costs.*
- *Award delay is a frequent issue. We do not do work without contracts anymore. It is our understanding that Interim Contracts are invalid after 180 days. There is a lot of confusion around Interim, short-term and long-term contracts regarding which are valid and who has responsibility. You can't run a business on short-term contracts.*
- *Does VA plan to increase the threshold for contracts when Directive 1663 is revised?*
 - **Ms. Benmark:** Per the revision of Directive 1663, we do not project an increase of the \$500,000 threshold.
- *A practitioner has on-call responsibilities as part of his/her regular duties. If they are also working for VHA, they will have additional on-call responsibilities. As a result, on-call for VHA should be a separate cost. On-call may also be part of the salary agreement with that physician. For an FTE-type contract, on-call responsibilities will be proportional to what is required. So, if on-call for VHA is in addition to what is already included in their salary VHA should pay.*
 - **Ms. Benmark:** Ensure your physician that is on-call for VHA is not currently on call for another hospital. VHA wants to make sure our own physicians are doing what they are required to do for on-call. VA Directive 1663 is specific about on-call requirements.
- *Can we reduce their on-call requirement?*
 - **Ms. Benmark:** VHA's on-call policy says that physicians will be available 24/7. We are looking into contacting medical centers to see how much physicians are actually doing. However, we need to collect this information based on the specialties of the doctors to ensure we are making appropriate comparisons.

VHA Café: Performance Metrics and Quality Assurance

Dr. Michael Hagan – National Director of Radiation Oncology for VHA

Dr. Hagan noted that Quality Assurance (QA) is the responsibility of the VA. It cannot be contracted out. There needs to be QA of the residency program, quality of performance, accreditation boards, and the care given. It is VA's responsibility to collect the data on performance, and the responsibility of the VA Service Chief to take action based on the results. QA is part of the contract. If it is not in the contract, it needs to be. In particular, each contract must spell out the specific requirements for the Service Chief.

Participants had the following questions and comments:

- *What are some examples of metrics for contract performance?*
 - **Dr. Hagan:** Every contract has a minimum set of metrics, but some have a robust performance metric program. A lot can be monitored electronically through the patients' charts. Whether a physician is hired by contract or directly by the VA, he or she should provide the same care for the Veteran. The Contracting Officer Representative (COR) will monitor

- contractors to ensure they are meeting performance measures. Also, when writing contracts, the Service Chief may add additional metrics as appropriate.
- **Ms. Hallmark:** The first thing to understand in contracts is that if it is a performance-based acquisition, so you must have some sort of metric process. If it is not in the Performance Work Statement (PWS), you would not know what is going to be measured.
 - *Can you provide an example of what a Quality Assurance Plan (QAP) should be?*
 - **Ms. Hallmark:** Yes, we will provide an example of a QAP. (**Action Item**) The PWS should be consistent with the QAP.
 - *Is it reasonable to assume that the same QA metrics are in each contract?*
 - **Dr. Hagan:** It is hard to argue with that. The radiology QA is very well spelled out, so it can be true in that area. There are administrative pieces that can be built into the contract by line item. We are striving for some uniformity across the medical fields.
 - *What should we expect if service is on a per-procedure basis at the Academic Affiliate? Is VA sending patients for service and getting information back from the Affiliate?*
 - **Dr. Hagan:** It is certainly not uniform. In radiology and oncology, it is required that the Affiliate's service be equivalent to VA or better, and they must be American College of Radiology (ACR) accredited, or perform at a VA level or better. More practices and Affiliates are moving to become ACR accredited.
 - *Is someone at VA monitoring that patients are being seen with this accredited service?*
 - **Dr. Hagan:** Yes, it is part of the contract offering when patients are off-stationed to another site. If a patient is sent out without a contract, then there is no monitoring. It is not under the same level of scrutiny as contracted work.
 - **Ms. Hallmark:** When sent out without a contract, it is under a fee basis agreement, not a commercial contract, and the Affiliate is not dealing with a contracting officer. The fee basis agreement is not random. It is the Chief of Staff's responsibility, and he/she performs an in-depth review of each case before approving.

VHA Café: Recruitment vs. Contracting

Speaker: Dr. Judy Brannen, Office of Academic Affiliations (OAA)

Dr. Brannen emphasized that VA is focused on doing what is best for the Veteran and encouraged participants to share their ideas for the best ways to share physician services between Affiliates and VA to accomplish this goal.

The facilitator invited participants to share their perspectives on models for sharing faculty and when sole source contracting should be considered.

- *Maryland has had a long history of positive relationships with VA in hiring part-time physicians like 7/8 and 8/8. In all cases except for one, the contracts have been a supplement not a replacement. The only issue we have, that doesn't come up often but can be a problem, is when there is a joint recruitment of an 8/8. The Dean will not provide an 8/8 person with a full-time faculty appointment, which means they will not be able to teach. We are working on a Memorandum of Understanding between VA and Maryland to make sure VA physicians hired are meeting the university's requirements.*

- **Dr. Brannen:** From an OAA perspective, to teach in a training program doesn't require an academic appointment. The person just has to be acceptable to the Program Director listed on the program Letter of Agreement between the program and sponsoring Affiliate.
- *Our school of medicine requires that in order to teach, the individual must be a faculty member. They could still receive an adjunct appointment – there are some departments that have only 8/8s.*
 - **Dr. Brannen:** At Virginia Commonwealth University (VCU) we're giving VA faculty an academic appointment, but this does not include benefits and pay, and other things. Also, if a physician is terminated from VA, then their academic appointment ceases. In addition, VA does have to advertise for positions they are looking to fill. Sometimes Chiefs of Staff are worried about advertising the positions because they feel that they have to hire that person. If the physician doesn't meet the requirements, then you don't have to hire them. Once you have interviewed people, then you can move on to a sole-source contract.
- *How does a 3/8s VA physician get her vacation paid?*
 - **Dr. Brannen:** There is more than one model for compensating part-time physicians for vacation. One is a straight tour of duty – for example, they must account for their time by signing in and out for a set number of days/hours. They then would accrue hours accordingly. The second is an hours bank. This is when the physician agrees to work a certain amount of hours (this includes core hours and variable hours) that they are then able to reconcile every quarter. If they are your only shared faculty, there are ways you can compensate them for when they are on leave. (Dr. Brannen agreed to provide additional assistance if participants needed further information.)
- *How do we make sure physicians can keep the incentives they received from VA?*
 - **Affiliate:** This may be specific to each university. When faculty members are paid from VA, then it is up to the department to track their salary. For example if someone makes \$150,000 a year, then they can't exceed this amount. So, then we have to reduce their university salary or request an increase from the Dean. In addition, each department would have to get tenure approval from Contracting Officer Representatives (COR). This is difficult and creates more administrative burden. Recently, we got VA to send a report on salary increases. I recommend requesting reports at least quarterly, because salary increases can take place at any time.
 - **Affiliate:** We've had similar issues with incentives. Some departments have a cap, so when the VA provides incentives the university may have to take it away. It becomes a morale issue.
 - **Affiliate:** We've allowed physicians to keep their incentives, but they just have to report it. It's important to keep the communication open between the VA and the academic center to really foster the relationship, so physicians are being rewarded for reaching benchmarks.
- *One of the drawbacks of recruiting an 8/8 person is reduced productivity, because the person is running back and forth between the clinic and trying to be in more than one place.*
 - **Dr. Brannen:** If 8/8 physicians have responsibilities at the Affiliate or work on committees, according to VA regulations, these should be done outside of the VA tour of duty. Physicians should tell the timekeeper where they are and if they are staying later. Lost productivity should be made up by the VA faculty members that are already providing other services.
- *Local hires are one of the strengths of the VA – this sometimes gets lost with Washington's rules, especially when the OIG is involved.*
 - **Dr. Brannen:** In regards to contracting, OIG really wants this to work and wants contracts that benefit veterans. They can be very helpful in the contracting process, especially if they are the table early. I wouldn't be fearful of the OIG review. They have been very fast with the turn around.

- **Ms. Hallmark:** We're working on getting clearer instructions and educating contractors on what to do, and OIG has been getting reviews done pretty quickly.

Participants provide their suggestions on various opportunities to improve recruitment, including:

- One potential opportunity is building a joint research building. This would provide greater insights for practitioners and additional opportunities.
- Another opportunity is in interstate recruitment. The VA should take out-of-state physicians on, even though they won't be able to obtain the state's license for 4-6 months. This way we can get someone in a timelier manner. We should hire them on and then switch them out later. Is there mechanism to do that?
 - **Dr. Brannen:** You can always figure out a way to hire a good hire. VA can sell physician services – the Affiliate pays for the services, but the money goes to VA. Bottom line – you've got to have communication at every level.
- VA will sometimes hire a faculty member that the university would never hire. The university then will not let these faculty members train their residents, because they feel the level of supervision needed is not there. This builds animosity. In order to create the best care for veterans, and also create a great residency experience we need to work together and come to an agreement on joint hires.

Credentialing and Privileging

Ms. Kathryn Enchelmayer – Director, Credentialing and Privileging

Ms. Enchelmayer reviewed some of the topics on the Frequently Asked Questions handout she provided to participants and encouraged participants to ask questions. She noted in particular that the Electronic Credential System can monitor how long credentialing takes. VHA promises to take 45 days or less, but this is only after a provider enters their information.

- *Are there any specific issues for foreign nationals?*
 - **Ms. Enchelmayer:** They have to demonstrate that they can be in the facility. If they have sponsorship visas, this raises additional questions. Institutional licenses allow for foreign nationals to practice at the Affiliate, and it is possible for them to get the highest possible clearance.
- *What if a physician is new to a VA Hospital, but has worked at another VA Hospital?*
 - **Ms. Enchelmayer:** If they went through VetPro before, then it should go faster the second time. VA will already have some references, but the physician still has to go through the same process (re-credentialing). VA will credential anyone who has licenses and certifications to practice.
- *Can one be privileged and not require a background investigation? Can they be done concurrently?*
 - **Ms. Enchelmayer:** If only the lowest level is needed, it should only take two to five days, as long as nothing is in their background. If they are denied by the adjudicator, then they cannot work with VA. There is a current backlog. Affiliates can start credentialing as early as they want.
 - **Ms. Benchmark:** There is a Standard Operating Procedure (SOP) required by VHA that we can provide attendees. **(Action Item)** Defining the new on-boarding and off-boarding procedure should also help.

Information Security

Mr. Donald Newman – Region 2 Information Security Director

Mr. Newman provided an overview of the responsibilities of an Information Security Officer (ISO). He noted that ISOs now review contracts. They are particularly interested in knowing that information is secure when it is in the hands of the Affiliate. He recommended that Affiliates separate VA data from other data to ensure that data can be transferred securely.

He then invited participants to ask questions related to information security and security reviews.

- *What happens when you have a team of doctors that rotate and are not back within 30 days?*
 - **Mr. Newman:** Before, they were getting deleted from the system, but VA is aware of the problem and the problem is being corrected.

Ask the VHA: Questions and Answers

Participants were invited to ask questions and provide input to VHA Senior leaders that may not have been addressed earlier in the day. Below is a summary of the questions and comments that were received.

- *Is there a tracking and monitoring system in place for how tracking all sole-source contracts and spending with Affiliate institutions?*
 - **Ms. Benmark:** Yes, the Electronic Contract Management System. When a contract is initiated and awarded, it is entered in the system. It is mandatory for VHA. They do have lists of contracts, so there may be reports that COs can run to better communicate status with Affiliates.
- *Is VA currently implementing any telemedicine contracts using the sole-source contracting approach?*
 - **Ms. Benmark:** There are initiatives that are currently being evaluated. There is an agreement in place, particularly in radiology. Rural Health is also getting involved in telemedicine. Most of these contracts are being competed, but some are essentially sole sourced. The security requirements are extreme, making it difficult to do on competitive basis. Tele-ICU is new, but Affiliates can offer a lot of opportunity to the smaller facilities.
- *Can the VA provide an Excel spreadsheet to include all detailed costs with formulas to calculate total costs?*
 - **Mr. Brian Vasbinder:** A sample was provided in the handouts, and VA is open to creating templates if Affiliates have suggestions. However, as noted earlier, all Affiliates are different and may have different pricing methodologies and compensation plans.
- *With respect to indirect and overhead calculations, why do Affiliates have to justify these items for VA and not other federal agencies?*
 - **Mr. Norbert Doyle:** VA has asked OIG if there is a way to allow a percentage of indirect costs without support documentation, because it is not cost effective to go through all the minute cost data.
- *Why has our fringe rate that has been accepted by other parts of the government not adequate for VA? Federal agencies need to work together. VA seems to set its own rules and regulations.*

- **Mr. Jan Frye and Mr. Doyle:** VA can look into this because it does make sense if it is accepted throughout the government, why not VA? There are differences however. For example, Health and Human Services (HHS) rates are based on education research, while VHA is actual service. We need to figure out what factors are different – some may be applicable while others may not. The components are there, but VA is just not using it. VA will review its fringe rate policy and determine whether or not some parts of that rate that have been approved by other agencies can be used for VA.
- *COs do not have healthcare experience. If you specialize and recruit within the industry, this may help decrease employee turnover.*
 - **Mr. Doyle:** We are hiring a lot of new people and a lot from the Department of Defense (DoD). We are hoping to develop expertise in all areas, not just healthcare. The organization is still growing and we'd like to take Ms. Benmark's model for developing specialty classes by industry.
 - **Mr. Frye:** COs are there to put contracts in place, not to be an expert. We need program managers that understand the requirements within the facility so they can properly put requirements together for the CO.
- *Is there an ability to use what they use at Affiliate trainings for COI, HIPPA, etc.?*
 - **Ms. Benmark:** VA does not know the contents of this training and not sure it covers all of their internal policies. These courses would have to be thoroughly reviewed and approved by different parts of VA, which would be a significant undertaking.

Closing Remarks

Ms. Benmark discussed post-Forum activities. She noted that VA will review the information that emerges from the three forums to identify key issues and topics for follow-up. She anticipated creating workgroups or conducting workshops to help further define these issues and help get them resolved. Webinars may play an important role in the education process so that all Affiliates can be more informed about policies and programs.

She thanked everyone for their participation and encouraged them to tell their colleagues about the upcoming forums and encourage them to attend if they are not already registered.

Appendix A: Forum Agenda

8:15 am	Opening/Welcome Ms. Karyn B. Rae, MBA Director, Managed Care - Medical University of South Carolina
8:30 am	Agenda Review and Introductions
8:45 am	The Value and History of the VHA-Affiliate Partnership Dr. Judy Brannen Clinical Director, Undergraduate and Graduate Medical Education, VHA Office of Academic Affiliations
9:30 am	The Contracting Process Charlie Benmark Medical Sharing/Affiliate Director, VHA Office of Procurement & Logistics
10:30 am	BREAK
10:45 am	The Pricing Challenge & Potential Tools Ms. Karyn B. Rae, MBA Director, Managed Care - Medical University of South Carolina Brian Vasbinder Procurement Analyst, VHA Service Area Organization (SAO) East
12:15 pm	Lunch
1:15 pm	Topic Café Sessions 1:15 – 1:50: Improving the Negotiating Process or Performance Metrics & Quality Assurance 1:55 – 2:30: Improving the Negotiating Process or Recruitment vs. Contracting 2:40 – 3:10: Credentialing and Privileging & Information Security
3:15 pm	Ask the VHA and Improvement Forum
4:15 pm	The Path Forward
4:30 pm	Close

Appendix B: Affiliate Attendees

Name	Job Title	Organization or Agency	Email Address	Preferred Phone
Joyce Barrett	Senior Administrator	UMass Medical School	joyce.barrett@umassmed.edu	508-856-2446
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Appendix C: VA Attendees

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