Department of Veterans Affairs **VA DIRECTIVE 1663**
Washington, DC 20420 **Transmittal Sheet**
August 10, 2006

HEALTH CARE RESOURCES CONTRACTING – BUYING TITLE 38 U.S.C. 8153

1. REASON FOR ISSUE: This Department of Veterans Affairs (VA) Directive implements provisions of Public Law 104-262, the Veterans Health Care Eligibility Reform Act of 1996, which expands VA's health care resources sharing authority in Title 38 United States Code (U.S.C.) Sections 8151 through 8153 (sharing authority). This Directive pertains to the acquisition of health care resources.

2. SUMMARY OF CONTENTS/MAJOR CHANGES: This Directive sets forth the policies and responsibilities for implementing and managing sharing agreements under Title 38 U.S.C, Section 8153-Enhanced Sharing Authority.

a. Veterans Integrated Service Network (VISN) Directors, Deputy Network Directors, Medical Center Directors, Heads of Contracting Activities (HCA), and Contracting Officers are responsible for compliance with the requirements outlined in this Directive, for meeting all requirements of law and policy, for meeting all labor management responsibilities, for the establishment of appropriate and legally-sound contract terms, for making sound business decisions, for ensuring that staff are properly trained and are fully capable of exercising any delegated authority, for ensuring adequate documentation of the contract price, and utilization and performance monitoring.

b. Consequences for staff not following the requirements of this Directive are delineated.

c. All Health Care Resources contracts, that do not require the acquisition of the services of Affiliated University faculty members to perform the services of the contract, must be awarded competitively when two or more providers that can fulfill VA contract requirements of the health care resource are available.

d. All Health Care Resources contracts awarded non-competitively that exceed the dollar thresholds defined in this Directive require a pre-award audit by the Office of Inspector General to be completed within the timeframe set forth in this Directive. When unusual and compelling urgency requires immediate contract award and performance, an audit must be performed post-award.

3. RELATED DIRECTIVE/HANDBOOKS: VHA Directive 1660.1, Selling-Health Care Resources Under 8153 Sharing Authority, and VHA Directive 1660.3, Conflict of Interest Aspects of Contracting for Scarce Medical Specialist Services and Health Care Sharing.

4. RESONSIBLE OFFICE: The Veterans Heath Administration Chief, Prosthetics and Clinical Logistics Officer (10FL), Office of the Under Secretary for Health.

5. RESCISSIONS: VHA Directives 97-015, 99-056, and 96-039 are rescinded.

CERTIFIED BY:

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HEALTH CARE RESOURCES CONTRACTING – BUYING
TITLE 38 U.S.C. 8153

1. PURPOSE: This Department of Veterans Affairs (VA) Directive further implements provisions of Public Law (Pub. L.) 104-262, The Veterans Health Care Eligibility Reform Act of 1996, which significantly expands VA's health care resources sharing authority in Title 38 United States Code (U.S.C.) Sections 8151 through 8153 (sharing authority). This Directive pertains to the acquisition of Health Care Resources.

2. POLICY

a. The medical center Director determines when additional health care resources are required. It is the policy of the Veterans Health Administration (VHA) to hire health care clinical staff whenever feasible. Hiring of staff needs to be done under appropriate employee appointment authorities, including, where appropriate, fee basis under 38 U.S.C. § 7405(a)(2).

b. When a qualified clinician cannot be recruited, or it is determined to not be in the best interest of VA to hire staff, the medical center Director must first consider sending patients to another VA medical center. Contracting for necessary services will only be considered if these options are not appropriate or viable. If contracting for services is required, competitive bid is the first option to be considered.

c. All contracts for physician services provided at VA must state that credentialing and privileging is to be done in accordance with the provisions of VHA Handbook 1100.19.

d. If the services provided under the contract include resident supervision, the contract requires compliance with VHA Handbook 1400.1 and should include a copy of Handbook 1400.1 as an appendix to the solicitation. ***NOTE:*** *VHA Handbook 1400.1 pertains to standards of resident supervision from the standpoint of quality care, patient safety, resident education, and residency program accreditation standards. Documentation related to billing is not included in the VHA resident supervision policy. Nevertheless, contracted services, including those on a per-procedure basis, are expected to meet VHA standards of resident supervision in terms of the qualifications of the contract physician to supervise residents and of the supervising physician's physical presence in clinical settings and procedural involvement, including pre-operative evaluation and post-operative care as specified in the policy*.

3. RESPONSIBILITIES

a. Veterans Integrated Network Director (VISN). The VISN Director is responsible for appointing the acquisition team for contracts at a Network level. The VISN Director approves or disapproves requests and justifications for sole source contracts with an Affiliate; is ultimately responsible for full compliance of all pertinent parties in their Network with this Directive; approves or disapproves requests and

justifications for the use of per-procedure contracts in lieu of Full-time Equivalent (FTE)-based contracts for services provided at VA.

b. Deputy VISN Director. The Deputy VISN Director approves or disapproves all requested deviations from this Directive; performs due diligence in verifying that Medical Center and Network staff have complied with this Directive; provides written certification that the process was followed; and takes appropriate action when made aware of a failure to comply with the Directive.

c. Medical Center Director. The medical center Director is responsible for appointing the acquisition team for all contracts at the facility level. The Director approves a requested health care need; hires staff to fill the identified need, if feasible; considers the most appropriate alternate method for fulfilling the need when recruitment efforts are unsuccessful or not in the best interest of the government; submits a justification, if the most appropriate alternate method is determined to be contracting out a health care need; submits a request and justification for a sole source contract with the Affiliate if the identified health care need requires the acquisition of the services of affiliated university faculty members to perform the services of the contract; submits a request and justification for use of a per-procedure based contract in lieu of an FTE-based contract for services to be provided at VA; recommends membership for an Acquisition Team; ensures that each Chief of Staff, all medical and surgical service chiefs, and any VA employees that could affect a contract, receives a copy of VHA Handbook 1660.3 and signs VA Form 10-21009 Acknowledgement Form; and approves a waiver to the general rule that part-time VA physicians should not provide the same services under contract for which they receive VA pay under special circumstances.

d. Medical Center Chief of Staff (COS). The medical center COS conducts a needs assessment; makes recommendation to the medical center Director regarding justifications of health care needs; and ensures that all appropriate quality standards are in place in the Statement of Work, the appropriate data methods are in place, collection is performed, and that the performance of medical care under a sharing agreement is monitored. ***NOTE:*** *These responsibilities must be assigned to another appropriate clinician, if the COS has a conflict of interest as defined in VHA Handbook 1660.3.*

e. Clinical Service Chief (CSC). The CSC identifies a health care need and, if it is not feasible to hire staff develops a Statement of Work in conjunction with the assigned Contracting Officer and Acquisition Team. ***NOTE:*** *These responsibilities must be assigned to another appropriate clinician if the CSC has a conflict of interest as defined in VHA Handbook 1660.3.*

f. Human Resources Manager. The Human Resources Manager provides written certification that recruitment efforts to fill an identified health care need were unsuccessful. This written certification needs to include a statement that the supporting recruitment documentation found in subparagraph 4a(1) is available for review.

g. Heads of Contracting Activity. Heads of Contracting Activity are responsible for implementation and oversight of all contracting requirements contained in this Directive.

h. Contracting Officer. A Contracting Officer is always a member of an acquisition team. The Contracting Officer develops acquisition planning document; conducts market research; develops a Statement of Work, including the technical evaluation criteria, in conjunction with the requesting Clinical Service Chief and Acquisition Team; completes the formal competitive or non-competitive solicitation process, as appropriate, based on justifications and approvals received from the Network Director; submits the solicitation to VHA Prosthetics and Clinical Logistics Office for legal and technical review (non-competitive for $500,000 or more and competitive for $1,500,000 or more); submits non-competitive contracts for $500,000 or more to the Office of Inspector General for a pre-award audit prior to initiating negotiations; submits final proposed contract and the Price Negotiation Memorandum to VHA Prosthetics and Clinical Logistics Office for pricing review; submits proposed contracts of $5,000,000 or more to the Office of Acquisition and Materiel Management; makes the contract award and completes Price Negotiation Memorandum; notifies the Deputy Network Director if aware that this Directive is not being followed at any point during the contracting process; submits requests for interim contract authority approval for services that are required immediately while pursuing the long-term contracting process; and ensures that copies of the applicable acknowledgements required under VHA Handbook 1660.3 are filed in the contract folder.

i. VHA Prosthetics and Clinical Logistics Office. The VHA Prosthetics and Clinical Logistics Office (PCLO) will provide administrative oversight and initiates policy guidance. The PCLO receives and distributes all solicitations over specified thresholds to the Office of Acquisition & Materiel Management, General Counsel, and Patient Care Services for review and approval, sends comments to the Contracting Officer, receives and distributes final proposed contract and Price Negotiation Memorandum to Patient Care Services for review, sends recommendations and approval memo to the Contracting Officer, provides approval or disapproval for requests for interim contracts required to provide services needed immediately while the long-term contract process is completed, prepares the annual report to Congress on activities carried out under the health care resources sharing program. The PCLO will maintain a data base on the use of sharing authority in VA.

j. Office of Acquisition & Materiel Management (OA&MM). OA&MM conducts technical reviews for solicitations over specified thresholds and provides recommended changes; conducts Business Clearances for proposed contracts of $5 million or more and provides recommended changes; and approvals or disapprovals as appropriate to the field Contracting Officer.

k. VHA Office of Business Compliance. The Office of Business Oversight includes a random review of health care contracts in their routine business audits to determine that all requirements of this Directive have been followed, and it provides an annual review of the deviations and justifications.

4. ACTION

a. Contracting for Health Care Resources. This paragraph provides general guidance that applies to all methods and types of Health Care Resources contracts. Additional, specific information regarding special requirements is included in subsequent sections.

(1) Prior to initiating a contract, the facility must ensure that a clinician could not be hired to fill the clinical requirements. A good faith effort to recruit must be demonstrated in accordance with VA Directive and Handbook 5005. A facility should not have to go through a lengthy recruitment process when that is not an option; however, the contract file must contain a document from the facility Human Resources Department that attempts to recruit a VA employee to fulfill the contract requirements were not successful at the time the services were required, but that recruitment efforts would continue, or a justification supported by the chief of the service and/or COS, and approved by the medical center Director, regarding why recruitment was not an option. As appropriate, the justification is to include specific types of services required, documentation for an equivalent number of full time equivalent (FTE), location of services to be provided, comparison of compensation packages, etc. ***NOTE:*** *Examples of documents required to demonstrate unsuccessful recruitment efforts include: a copy of the vacancy announcement; a copy of any paid or unpaid advertising; a list of recruitment sources; a copy of responses received from applicants, if any; and justification supporting the decision not to select any of the applicants.*

(2) All health care resources contracts that do not require the acquisition of the Affiliated University faculty members' services to perform the contract services must be awarded competitively when two or more qualified providers (may include the Affiliate) of the health care resource are available that can fulfill the VA contract requirements.

(a) Sole-source awards with affiliates must be considered the preferred option whenever education and supervision of graduate medical trainees is required (in the area of the services contracted). The contract cost cannot be the sole consideration in the decision on whether to sole source or to compete.

(b) The decision to compete contracts for services that overlap programs in which the facility has graduate medical education training in place must be weighted by additional factors beyond the contract costs. The decision must consider all implications to the business, including the impact to the facility's training program, which is a direct contributor to the facility's productivity and may provide offsets. VA is committed to various graduate medical education training programs as a part of the VA training mission. Accreditation Council for Graduate Medical Education and medical school policies require that physicians supervising resident trainees hold faculty appointments at the accredited institution.

(3) Assuming there are no conflicts of interest, justifications for sole source

contracts with the Affiliate must be submitted by the medical center Director, through the Network Chief Medical Officer and approved by the Network Director, prior to submitting to the Contracting Office. The justification must include all of the information in subparagraph 4a(1), as well as whether the contract will be FTE or per procedure based (see subpar. 4b for additional guidance pertaining specifically to the sole source contracting process).

(4) Prior to solicitation, alternate source plans (e.g., attempt to hire on a dual path with contracting, fee, etc.) must be established in the event a contract cannot be awarded.

(5) **Establishment of Acquisition Teams.** Medical Centers and Networks are required to use a multi-disciplinary team approach in acquisition of health care resources. When a requirement is identified for a health care resource, an Acquisition Team must be established to coordinate the activity. The determination of the membership of the team is at the discretion of the facility or Network; however, at a minimum, clinical staff that can represent the Chief Medical Officer or COS as a Contracting Officer's Technical Representative (COTR) and a Contracting Officer are required. The Contracting Officer and COTR must have sufficient knowledge of the operation of the facility and the service requesting the contract to ensure that services to veterans will not be compromised and that the resource to be purchased is consistent with the overall mission of the facility. Other team members need to include: finance, business office (such as, Business Manager, Fee manager, Medical Care Collection Fund (MCCF) Manager, Health Information Management System (HIMS) Manager, Coding Manager), quality assurance, or staff involved in utilization review, as appropriate.

(6) The decision to procure health care resources must be based on an independent government cost estimate that is based on a needs assessment and a market survey. The market survey must identify the potential offerors available, performance standards, and market prices from other community providers and, Medicare and professional society compensation survey information. ***NOTE:*** *A Professional salary survey from the Association of American Medical Colleges (AAMC) and the Medical Group Management Associations (MGMA) may also be used in the market survey and are available at the following web address: http://vssc.med.va.gov/sharingagreements/main.asp. These salary surveys will also be available by contacting the Office of Prosthetics and Clinical Logistics.* The results of this market survey must be made part of the contract file, support the outcome of the negotiation, and support the rationale for actions taken. Medicare rates may be used for negotiating prices when a procedure-based contract is contemplated. Contracting officers are responsible for researching all component costs included in the Medicare rate and for using those component costs in conducting negotiations. A contract award to provide health care to veterans should be a Best Value-based evaluation using factors and significant sub-factors that are tailored to the acquisition. At a minimum, price, quality, timely patient access, technical actions and, past performance factors need to be used.

(7) The rate of reimbursement for a negotiated health care resources contract price must be FTE-based, per-procedure (Current Procedural Terminology (CPT) or Diagnostic Related Group (DRG)) or capitation (authorized for use in Community-based Outpatient Clinic (CBOC) contracts only). Other reimbursement methodologies that benefit VA and veterans are also approved, when appropriate, by the VA Central Office Prosthetics and Clinical Logistics Office in coordination with the Office of Patient Care Services; existing examples include "global" rates for organ transplant. ***NOTE:*** *The Prosthetics and Clinical Logistics Office maintains a database on reimbursement methodologies that could be applicable at other facilities at* *http://vssc.med.va.gov/sharingagreements/main.asp* .

(8) **Per-procedure Contracts**

(a) The facility or Network must have a system in place for monitoring what procedures are being done, performance, which physicians are performing the procedure, and a method for verifying the invoices for procedures performed. The monitoring system will be different based on whether the patient is treated at a VA facility or at the Contractor's facility. This system could be electronic or involve manual coding by staff. Contracts should be indefinite delivery, indefinite quantity (IDIQ). Centers for Medicare and Medicaid Services (CMS) regulations establish the requirements for the participation of the attending physician in procedures and examinations to qualify for payment. A reference to Title 42 Code of Federal Regulations (CFR) 415.170 as a condition of payment must be included in all per-procedure contracts.

(b) The following CFR Sections must be referenced as a condition for payment in contracts for these services:

1. Title 42 CFR. 415.176 (contracts for renal dialysis).

2. Title 42 CFR 415.178 (contracts for anesthesia services).

3. Title 42 CFR 415.180 (contracts for diagnostic radiology and other diagnostic services).

4. Title 42 CFR 415.184 (contracts for psychiatric services).

NOTE: *See subparagraph 4b(1)(b) for other requirements for sole-source per-procedure contracts.*

(c) Per-procedure contracts for services performed at the VA can only be considered if there is an approval by the Network Director based on written justification showing that a procedure-based contract is in the best interests of the Government. Proposals for services provided at VA on a per-procedure basis need to be based on the work and malpractice components of Medicare Part B.

(d) Per-procedure contracts for services provided at the Contractor's place of business need to be based on both Part A and Part B of Medicare Prices, and adjusted to ensure VA only pays for services actually provided.

(9) FTE contracts must specify the percentage of time each FTE will spend in patient care and non-patient care activities (i.e., administrative duties, such as attending certain types of meetings, attending rounds, research, training, etc.). The primary focus of these contracts is patient care. Hours assigned to research will be for VA-approved research performed at VA. FTE is defined by VA as a minimum of 80 hours every 2 weeks and does not include holidays. On call, weekend, and holiday coverage need to be specifically described in the statement of work. Physicians who work both part-time for VA and as VA contractors are encouraged to provide on-call services on a without compensation (WOC) basis as a VA employee proportionate to the percentage of time they devote to VA (e.g., 1/8, 3/8, etc.). On-call will not be separately broken out, unless the physician obtains separate on call pay at the Affiliate. If such coverage is required, the statement of work needs to include specific language requiring the contractor to provide the coverage in such a way as to ensure that the contract physician is not providing concurrent on-call duty to both VA and another hospital for the same periods of time. There might, however, be situations where certain medical specialists are very limited and concurrent on-call duty may be required, or due to the nature of the services which need to be provided; concurrent on-call will not impact patient care. In these circumstances, the Medical Center Director must approve any deviations to this requirement.

(10) All FTE-based contract statements of work must identify the key personnel proposed to provide the required services and their qualifications. Additionally, the statement of work needs to state that the contractor cannot change key personnel without VA approval, and when changes in key personnel are approved, the contract prices may be adjusted accordingly to reflect the salary and benefit of the personnel actually providing the services. When multiple physicians are expected to provide services under the contract, compute annual, monthly, or hourly rates, depending on the statement of work or other requirements in the solicitation, for each physician identified as key personnel. Require the Affiliate and/or practice group to provide data showing the total number of hours each of the physicians is required, or expected, to work annually, and use this information to negotiate contract prices.

(11) FTE-based Health Care Resources contracts must be based upon data provided that supports the proposed price, including, but not limited to, base salary, fringe benefits, and liability insurance. This data must be compared to information obtained in the market survey. VA must obtain sufficient cost or price data, not certified, from the sharing partner and/or the local market in order to determine price reasonableness (see Federal Acquisition Regulations (FAR) 15.403-3). However, as described in sub-paragraph 4a(6), price is only one of the factors required to determine a best value for the government.

(12) All Health Care Resources contracts, including those not reviewed by VA Central Office, and those awarded competitively must include a memorandum signed by

the official responsible for establishing the Acquisition Team, i.e., medical center Director or Network Director, containing the following language: "It is hereby certified that to the best of my knowledge, all discussions and negotiations relating to this solicitation were conducted in the presence of the Contracting Officer. No VA employee with any financial relationship with (name of affiliated institution, associated teaching hospital, or other provider) participated in actions involving this solicitation," (see 18 U.S.C. §208).

(13) The contract file for all health care resources contracts must contain written documentation from the clinical personnel utilizing the contract services that, "The contractor meets the quality requirements VA's contract and the staff and facility of this contractor is approved." This certification must be signed and dated by the responsible clinical personnel, and must be received by the Contracting Officer prior to making an award.

(14) If services for a medical specialist at VA are required, the Contracting Officer also needs to consider the use of 38 U.S.C. §7409 for Scarce Medical Specialist Services. ***NOTE:*** *The authority and restrictions for use of 7409 are found in VA Acquisition Regulations (VAAR) 806.302-5 (a).* This authority may only be used when services are being provided by the affiliate at the VA facility on an FTE basis. Section 7409 authority allows greater flexibility in that it is not limited to a firm fixed price. For example, 7409 authority needs to be considered if it is determined that a cost-reimbursement contract, or another type of fixed-price contract prohibited by FAR 12.207 would be in the best interests of VA. However, a Justification for Other than Full and Open Competition must be prepared by the Contracting Officer and approved by the Head of Contracting Activity for sole-source contracts with the Affiliate. Such sole source contracts can only be awarded to the affiliated academic institution, not their associated physicians or practice groups. Additionally, 7409 limits the types of health care resources to Medical Specialists only, and cannot be utilized for the expanded definition of health care resources found in 38 U.S.C. 8153.

(15) Estimated timeframes for completion of the contracting cycle are included in Appendix D, Health Care Resources Decision Tree. Facility and Network management must ensure that adequate time is allowed for Contracting Officers to complete the contracting process, as indicated by the specified timeframes (see App. D).

(16) The Prosthetics and Clinical Logistics Office is responsible for coordinating the review and communicating the results to the facility submitting the proposed solicitation for review. Non-competitive solicitations valued at $500,000 (total value of contract with option years) or more, and competitively-awarded solicitations valued at $1.5 million or more, may be issued only after legal and technical review by VA Central Office. Local officials are responsible for incorporating any changes required by the legal and/or technical review before the solicitation is issued. Solicitations requiring legal and technical review, including the appropriate clinical service, must be sent via Microsoft Exchange to the Prosthetics and Clinical Logistics Office (10FL).

(17) A website, with samples of VA Central Office-approved health care Resources contracts, is maintained by the VHA Prosthetics and Clinical Logistics Office. Occasionally, executed health care resources contracts, including the changes required in the VA Central Office legal, technical, and program office review, are requested from contracting officers for posting on the website. These health care resource contracts serve as samples for facilities considering similar contracts. The website address is: http://vaww.vhaco.va.gov/logistics/sow1.htm

(18) If electronic copies of the solicitation are provided to a contractor, it needs to be provided in a PDF format to preclude any changes to the solicitation by the contractor.

(19) If the contract is $5 million or more, OA&MM is required to complete a Business Clearance Review, in accordance with VAAR 801.602-70.

(20) After final pricing has been determined by the Contracting Officer, the contract is sent to VHA Patient Care Services through the Prosthetics and Clinical Logistics Office (10F) for final review and approval. Additionally, the Director's and/or COS's certification memorandum documents regarding Conflict of Interest must be included. An approval memo is faxed to the facility Contracting Officer.

b. Sole-Source Contracts. In addition to the guidance in preceding subparagraphs 4a(1)-4a(20), the following is specific to sole source contracts. VA must obtain sufficient cost or price data, not certified, from the sharing partner in order to determine price reasonableness (see FAR 15.403-3). However, as described in subparagraph 4a(6), price is only one of the factors required to determine a best value for the government.

(1) **Determination of fair and reasonable pricing**

(a) While complying with all applicable laws and regulations, the price basis for acquiring health care resources should be as flexible as possible. At a minimum this should include the direct purchasing of provider time (by FTE or by hour) and health care services (cost per procedure or relative value unit (RVU)-based contracts), as appropriate. Similarly, VHA should be allowed to use the same reimbursement methodologies as other government agencies, such as the Centers for Medicare and Medicaid (CMS), CHAMPVA, or TRICARE.

(b) Contracts should be based on market prices as assessed by appropriate local and regional market analyses. Contracts should not exceed applicable Medicare rates unless there is adequate justification documented in the contract file.

(c) Additional requirements for contract physicians (such as administrative activities, supervision of trainees, on call availability, rounds, etc) and/or additional contract requirements (such as credentialing, technology infrastructure, etc) may be examples of potential justifications for exceeding the Medicare rate. Medicare itself acknowledges the additional costs of providing medical education through the Indirect Medical Education supplement provided to teaching hospitals.

(2) **Contracts for work performed at VA**

(a) FTE-based Contracts. Proposed prices for FTE-based health care resources contracts with affiliated institutions might include "administrative overhead," or other non-salary costs related to services being provided to VA under the contract. They must be included as part of the negotiated price, rather than as a separate line item. Allowable costs for FTE-based contracts include items such as salaries, fringe benefits, medical journals, professional dues, malpractice insurance, and other direct costs. Unallowable costs include, such items as general department or university overhead and other indirect costs. In negotiating contracts for health care resources with affiliates, the primary principle is for VA to reimburse the Affiliate for all direct expenses associated with the contract (see subpars. 4a (9)-4a(11) for other requirements for FTE-based contracts).

(b) Per-procedure Contracts. All non-competitive per-procedure based contract files and submission packages for Health Care Resources contracts must contain the percentage of the locally specific Medicare rate for the appropriate procedure. ***NOTE:*** *This information is available from the CMS web page: http://www.cms.hhs.gov.* If the per-procedure Health Care Resources contract involves the physician performing the procedure at VA, then the rate of reimbursement is for the work and malpractice component of the Medicare Part B rate only. The overhead (practice) component of Medicare Part B rates will be excluded from the per-procedure price paid. However in those circumstances where some payment for overhead is appropriate, overhead is included as a separate line item and evaluated in accordance with FAR 15.4 and FAR 31. Per-procedure contracts must be IDIQ, unless otherwise justified. Payments are based on the actual procedures performed, not estimated procedures. Solicitations need to delineate specific administrative responsibilities (such as attending certain types of meetings, attending rounds, etc.) and prices for such duties so that they can be negotiated as a separate line item. If the administrative services are not provided, VA will withhold payment in accordance with FAR.

(3) **Contracts for Work Performed at the Affiliate.** The contract needs to allow for prices for Medicare Part A (hospital) and Medicare Part B (physician) and will be adjusted to ensure VA only pays for services actually provided at the Affiliate. During contract negotiations VA must consider reimbursing in-kind pharmaceuticals when appropriate, and pharmaceutical costs are to be deducted from the Medicare Part A, or other negotiated rate, unless an analysis of costs shows that it would be cost neutral, or not cost effective, or it would not be legally allowable. The awarded contract price must not contain any pharmaceutical costs if it is negotiated in this manner. Such circumstances may include high-cost pharmaceuticals provided for transplant operations. A process must be established at the local facility for the contractor to track pharmaceuticals used for each patient, and submit to VA a request for reimbursement of in-kind pharmaceuticals. This process needs to include a review and approval by an appropriate VA clinician to verify appropriateness of the request, and to authorize Pharmacy Service to issue the pharmaceuticals to the contractor. Additionally, if the

contract is for transplant operations, a method for transmitting the VA's costs for these pharmaceuticals to the VHA Transplant Office must be established in order to facilitate reimbursement to the local facility.

(4) All fair and reasonable pricing for health care resources contracts must be determined in accordance with FAR 15.404-2. All FTE-based non-competitive health care resources contract files and submission packages for VA Central Office review and approval must contain sufficient price comparison data to justify the negotiated prices reflected in the proposed contract.

(5) Include a requirement in the solicitation for the Affiliate to provide specified cost and pricing documentation with their initial offer for FTE-based contracts, for the Office of Inspector General (OIG) to use in conducting a pre-award pricing review (see App. B for detailed information regarding requested documentation). If the Affiliate is unwilling to provide any element of the information in Appendix B, inform the OIG, and they will request the Affiliate provide the information.

(6) While profit is generally discouraged, contracting officers need to specifically ask whether profit is included in the offer, and negotiate the amount to be approved in accordance with FAR Part 15.404-4. During the negotiation process, the Contracting Officer needs to aggressively discourage the allowance of profit as a factor in pricing the agreement. Affiliates may attempt to include profit either directly or indirectly, as a cost element in their offers. They may attempt to include profit as unspecified "overhead," inflated salary estimates, or in other ways. Because these contracts are non-competitive, and the medical school received other benefits through its affiliation with VA, profit needs to be discouraged. The Affiliate derives significant benefits from the affiliation agreement such as VA's training of residents at VA medical centers. Contracting officials need to carefully scrutinize all cost or pricing data elements and to discourage profit on contracts with affiliates. ***NOTE:*** *If any profit is allowed, it must be shown as a discreet item in the cost or pricing data.*

(7) The documents required for legal and/or technical review must include the solicitation, a certification stating why the facility could not hire, and the justification for sole-source.

(8) All non-competitive initially signed proposals valued at $500,000 or more require a pre-award audit by the OIG, prior to beginning price negotiations, except as set forth in the following.

(a) The OIG must complete the pre-award audit within 20 business days. Thereafter, the Contracting Officer may proceed with award.

(b) Upon determination by the Contracting Officer that unusual and compelling urgency requires immediate award without a pre-award audit, the OIG shall perform a post-award audit of the contract.

(9) Following the OIG review, negotiations with the Contractor commence. If the

contract is under $5,000,000, the VA Contracting Officer may execute the contract upon incorporation of any required changes and final negotiations.

c. Interim Contract Authority

(1) All proposed health care resources contracts must be approved by the VHA Prosthetics and Clinical Logistics Office before award (VARR 801.602-70). In an approved class deviation from this regulation, the Clinical Logistics Office (10F) may approve "interim contracts" prior to obtaining the full legal and technical reviews required by the regulation. Following the execution of all interim contracts, a copy of the interim contract must be sent to the Clinical Logistics Office (10F). Interim contract authority is established to provide required health care resources on an emergency basis for short-term needs, or as an interim measure to complete the contracting cycle for long-term needs, in accordance with this Directive. All new health care resources contracts should include FAR Clause 52.217-8, "Option to Extend Services," and medical centers must ensure that recurring needs are submitted in sufficient time to complete the contracting process and minimize the necessity to request interim contract authority.

(2) The terms and renewals of interim contract authorities are strictly limited. Interim contract authorities are approved for 180 days. Additional interim contract authority may be granted on an exception basis, not to exceed 1 year.

(3) When executing an interim contract authority, the contractor must be informed in writing that this is an interim measure for providing services. If the resources have not recently been provided under a contract, the contractor must also be told in writing that costs paid do not constitute acceptance of that price for any long-term contract currently being negotiated.

(4) Interim Contract Authorities under 38 U.S.C. 8153 are subject to Full and Open Competition, with the exception of contracts negotiated and awarded to the institutions affiliated with VA (See VAAR 806.302-5). Receipt of interim contract authority only permits the Contracting Officer to contract for a limited time period without the normal central office reviews and approval. All FAR and VAAR requirements apply to the proposed interim contract, including contract performance monitoring and conflict of interest provisions.

(5) Requests for Interim Contract Authority must be made on a memorandum from the VA medical center Director and approved by the Network Director through the Chief Medical Officer (see App. C). The following information must be provided: facility name; date of request; type of services; quantity of services (i.e., one FTE, three procedures, 17 days, etc.); description of services (requirements); length of authority requested (number of days); contractor name and whether this is a competitive or sole source procurement, and whether it is a new request or extension of an existing interim contract authority (include the number of times interim contract authority has been

requested for these services); total estimated cost, and the VA Medical Center contact person (name and phone number).

(6) All requests for Interim Contract Authority must be submitted to the Clinical Logistics Office (10F) via electronic mail, utilizing the sample memorandum format in Appendix C. Facilities are notified of the approval or disapproval of a request via electronic mail within 5 workdays after receipt of the request, and this will be kept in the official contract file. **NOTE:** Interim contract data is tracked in the Enhanced Sharing database at http://vssc.med.va.gov/sharingagreements/main.asp.

d. Quality Assurance and Performance Monitoring

(1) All care provided under a health care resources contract must meet VA quality standards of care, whether the care is provided in a VA facility or in the sharing partner's facility. The COS or Chief Medical Officer at the VA facility or Network level is responsible for ensuring that: the appropriate quality assurance standards are in place, the appropriate data methods are in place, collection is performed, and the performance of medical care under a sharing agreement is monitored.

(2) The solicitation must contain a detailed description of the monitoring procedures used by the VA to ensure contract compliance. These procedures must be able to demonstrate through time and attendance logs, operating room records, minutes of meetings or other appropriate electronic records, that VA has received services called for under the contract. This description must identify the VA official(s) by title to be designated as the COTR, who is responsible for verifying contract compliance. After the contract is awarded, any incidents of contractor noncompliance as evidenced by the monitoring procedures must be forwarded immediately to the Contracting Officer.

(3) The COTR must forward the summary evaluation of the contractor performance to the Contracting Officer annually prior to exercising any option year.

e. Determination of Conflict of Interest

(1) Provisions in the United States criminal code prohibit an employee from participating in the procurement of a health care resource if the employee has certain relationships listed in VHA Handbook 1660.3, with the non-VA parties involved in the procurements. The criminal code also prohibits the supplementation of an employee's salary for duties the employee performs as a Federal employee. VHA Handbook 1660.3 provides definitive guidance on how the criminal code provisions limit VA employees' activities with respect to sharing contracts, and delineates situations where facilities must seek Regional Counsel or Central Office ethics staff guidance (see VHA Handbook 1660.3).

(2) VHA Handbook 1660.3 is aimed at officials who as VA employees can recommend, prepare, negotiate, select, decide, evaluate, oversee, analyze, or otherwise affect covered procurements and contracts. On an annual basis, the facility Director must ensure that each COS, all medical and surgical chiefs and any other

facility VA employee that could affect a contract receive a copy of VHA Handbook 1660.3. VA employees must read and sign VA Form 10-21009, because their VA job involves the opportunity to affect a VA contract. Each signed acknowledgement must be placed on the right side of the VA employee's Official Personnel Folder.

(3) The medical center Director and the Contracting Officer must ensure that the contract file also contains a copy of the acknowledgement required under VHA Handbook 1660.3 for every VA employee who participated in the Health Care Resources contract and fits the description in preceding subparagraph 4e(2).

(4) It is a general rule that part time VA physicians should not provide the same services under contract for which they receive VA pay. However, under special circumstances, a waiver may be approved by the Medical Center Director in consultation with Regional Counsel, and a copy will be filed in the Contract file.

(5) Organizational Conflict of Interest Prohibition on Contract Employees. In addition to the restrictions placed on employees by the criminal code and VHA Handbook 1660.3, the organizational conflict of interest provisions of FAR subpart 9.5 prohibit contract health care professionals employed by the non-VA parties to a procurement from participating in the procurement on behalf of VA

f. Annual Report to Congress. The Clinical Logistics Office (10F) is responsible for the preparation of an annual report to Congress on activities carried out under the health care resources sharing program, as required by 38 U.S.C. Section 8153 (g). The annual report is prepared based on information provided in the Enhanced Sharing Database at: http://vssc.med.va.gov/sharingagreements/main.asp . In response to an annual data call, each medical center must complete the database entry for the actual expenditures for the fiscal year for each Health Care Resources contract. Medical centers are also requested to furnish comments on the effectiveness of the program, the degree of cooperation from other sources (financial and otherwise), and any recommendations for the improvement or more effective administration of the program.

g. Consequences for Failing to Follow this Directive. Failure to follow the requirements of this Directive and governing law and policy will result in appropriate administrative action that could include disciplinary action(s) and civil or criminal proceedings. In taking disciplinary or adverse actions, supervisors need to give consideration to several factors when determining what action is appropriate, including the nature and gravity of the Directive requirements that were not followed, the degree of willfulness of the employee's violation, its effect on VA interests, the existence of either mitigating or aggravating circumstances, the frequency of the offense, and the employee's position.

(1) All deviations from the requirements of this Directive must be thoroughly justified and approved by the pertinent Deputy Network Director. Conflict of interest requirements cannot be waived. A copy of the approved deviation document must be

filed in the official contract file, and included with the package submitted to VA Central Office for review or audit of the solicitation and/or contract documents.

(2) The Deputy Network Director is expected to perform due diligence in verifying that Medical Center and Network staff have complied with this Directive in its entirety. Such due diligence may include written certification from appropriate medical center staff. The Deputy Network Director and responsible Contracting Officer must provide written certification that the process was followed. A copy of the written certification document must be filed in the official contract file, and included with the package submitted to VA Central Office for review or audit of the solicitation or contract documents.

(3) If the Contracting Officer becomes aware that the Directive is not being followed, the Contracting Officer is responsible for notifying the Deputy Network Director of the issue, and the Deputy Network Director is responsible for taking appropriate action.

(4) Additional oversight is provided by the VHA Office of Business Compliance in regard to compliance with this Directive by, as part of their routine business audits, including an annual review of the deviations and justifications.

5. REFERENCES

a. FAR.

b. Public Law 104-262, Section 301.

c. Title 38 U.S.C. Sections 8151-8153.

d. Title 38 U.S.C. Section 7409.

e. VAAR Parts 801 and 873.

f. VA Directive and Handbook 5005.

g. VA Directive and Handbook 5025, Part IV.

h. VHA Handbook 1660.3.

6. DEFINITIONS

a. Health Care Resources. The term “health care resources” involves the provision of a broad range of health and medical services, including medical specialties, such as: radiology, cardiovascular surgery, etc. Health care resources also refer to health care support and administrative resources, the use of medical equipment, space, and home oxygen. Health care support and administrative resources include those services, apart from direct patient care, determined necessary for the operation of VA facilities. Health care support resources serve medically-related purposes (e.g.,

biomedical equipment repair, patient transport, etc). Administrative resources include services not unique to the provision of medical care, but deemed necessary to support the operation of a medical center (e.g., transcription services, grounds maintenance).

b. Health Care Providers. The term "health care providers" includes health-care plans and insurers and any organizations, institutions, or other entities or individuals who furnish health care resources.

c. Sharing Authority. Title 38 U.S.C. 8153, is the contracting authority for the mutual use, or exchange of use, of health care resources between Department health care facilities and any health care provider, or other entity or individual. Under sharing authority, VHA may enter into health care resources contracts (agreements) for the acquisition of health care resources with any health care provider, or other entity, group of individuals, corporation, association, partnership, State or local governments, or individuals.

d. Commercial Service. A commercial service is a service that is offered and sold competitively in the commercial marketplace, is performed under standard commercial terms and conditions, and is procured using firm-fixed price contracts. Firm fixed price with economic price adjustments are authorized by the FAR and should be used for option years. For procedure based contracts, the option year increases will be related to increases (or decreases) in Medicare. For FTE, they will be related directly to changes in salaries and benefits for the providers. It protects both parties.

e. Indefinite Delivery Indefinite Quantity (IDIQ). An IDIQ contract provides for an indefinite quantity, within stated limits, of supplies or services during a fixed period. The Government places orders for individual requirements. Quantity limits may be stated as number of units or as dollar values.

f. Pub. L. 104-262, Section 301. Pub. L. 104-262 Section 301, dated October 9, 1996, contains provisions, which eliminate barriers and disincentives to the sharing of health care resources with non-VA entities. VHA Directive 1660.1 contains information on the types of resources that can be shared, and who qualifies as a sharing partner under the expanded authority; it also addresses issues primarily related to selling VA health care resources that are not fully maximized. This Directive addresses issues related to the acquisition of health care resources under sharing authority.

g. Health Care Resources Contracts. VHA may enter into Health Care Resources contracts for the acquisition of health care resources, including hospital and ambulatory care, mental health services, medical and surgical services, examinations, treatment, rehabilitative services and appliances, preventive health care, home care, hospice, blood products, and other health care services.

h. Non-competitive Health Care Resources Contract. VHA may enter into a non-competitive Health Care Resources contract with an affiliated academic institution, a teaching hospital associated with an affiliated medical college, or an individual

physician or practice group associated with the medical college or associated teaching hospital.

CHECKLIST FOR HEALTH CARE RESOURCES SHARING AUTHORITY CONTRACTS (Title 38 U.S.C. § 8153) (For completion by the VA Contracting Officer)

Have the following items been completed or processes been followed?

1. A clear and specific Statement of Work describing the resources to be procured or provided.

2. In proposed contracts to procure the services of health care professional(s), certification that these personnel cannot be hired using conventional employment practices or would not be the most effective use of resources.

3. A description of Department of Veterans Affairs (VA) health care facility efforts to recruit the staff members.

4. Justification approval of the need for the services.

5. Justification approval for a per-procedure contract in lieu of an Full-time Equivalent (FTE)-based contract for services performed at VA.

6. A statement explaining how, in relation to cost, limited availability or unusual nature, the health care resource is either unique in the medical community, or is subject to maximum utilization only through health care resources contracting, and that other alternative sources existing within a geographic area were considered.

7. Although approval of justification for use of other than full and open competition. (Federal Acquisition Regulations (FAR) 6.303-1 and 6.303-2; and VA Acquisition Regulations (VAAR) 806.304) does not apply to sole-source contracts with an affiliate, or entities associated with an affiliated institution (VAAR 873.104(b)), it is required under this Directive.

8. Include a detailed description of the monitoring procedures used by the VA facility to ensure contract compliance.

9. Include a Section indicating prices and/or costs.

10. Total cost of the resources to be bought by VA.

11. Statement of methodology used to determine the cost of those resources and certification that the quantity of the resources and prices to be paid are reasonable and cost effective. A price analysis must be completed in accordance with VA Directive 1663, Health Care Resources Contracting - Buying.

12. Cost or pricing data (for non-competitively negotiated contracts of $500,000 or more). (see FAR 15.403-4 and 15.403-5).

13. Price Negotiation Memorandum. (see FAR 15.406-3; VAAR 815.8)

14. Full name and address of the contractor.

15. A statement declaring that the contractor is a health care provider, as defined by VA Directive 1663, Health Care Resources Contracting – Buying.

16. Include a requirement for the contractor to provide a list of key personnel to be provided under the contract.

17. Certification that effective controls are in place to monitor contractor performance.

18. Written documentation from the clinical personnel utilizing the contract services that "the contract meets the quality requirements of the contract and the staff and facility of this contractor is approved." Statement must be signed and dated by pertinent clinical staff.

19. Include VAAR 852.237-7 (Identification and Medical Liability Insurance).

20. Include FAR Clause 52.217-8 (Option to Extend Services).

21. Written certification from both the facility Director and Chief of Staff that the contracting officer conducted or controlled all contract negotiations and that there were no discussions between VA officials and the contractor's personnel about the contract at which the contracting officer was not present.

22. Prior to issuing the solicitation, submit for Legal, Technical, and Clinical review by appropriate VA Central Office program offices. (Contracts of $500,000 or more – Non-competitive, Contracts of $1,500,000 or more – Competitive.)

23. Review of prices by appropriate VA Central Office Patient Care Services program office(s) of a proposed contract prior to the award (the contract has previously received legal, technical, and clinical review by VA Central Office). (Non-competitive Contracts of $500,000 or more, Competitive Contracts of $1,500,000 or more, and all transplant contracts for any value.)

24. Office of Inspector General (OIG) Pre-award Audit for sole-source contracts of $500,000 or more completed prior to initiating negotiations.

25. A copy of OIG pre-award pricing audits for proposed non-competitively negotiated contracts of $500,000 or more.

26. Legal or clinical review for proposed modification(s) to an approved Health Care Resources contract for changes over $25,000.

27. A Business Clearance submitted, reviewed, and approved prior to making an award, for all contracts of $5 million or more.

COST AND PRICING DOCUMENTATION TO BE SUBMITTED BY SOLE-SOURCE CONTRACTOR (PRELIMINARY REVIEW MATERIALS NEEDED FOR FULL-TIME EQUIVALENT (FTE)-BASED REQUIREMENTS)

1. Physician employment agreements for all physicians who will be providing services under the contract. These agreements need to specify what portion of their respective salaries the University pays and what portion the practice group pays, if applicable.

2. If any portion of any of the salaries paid to physicians identified in preceding paragraph 1, is funded by grants, provide the details of those grants to include the amount of the grant and the percentage of the physician's time dedicated to fulfilling the grant obligation. If there is no grant funding, provide a statement to that effect. If any portion of an individual salary is paid for by sources other than grants, the practice group, or the university, please provide the amount and the source of the funding.

3. Detailed support for fringe benefit expenses. This support needs to include what is included in the amount along with supporting documentation for the expense. Fringe Benefits need to be broken down by organizational entity, e.g., University or Practice Group.

4. Detailed support for any overhead expenses. This support needs to include what is included in the amount, along with supporting documentation for the expense. Include adequate documentation detailing the method of allocating expenses to the department and/or physician. These expenses need to be broken down by organizational entity, e.g., University or Practice Group.

5. Supporting documentation for the professional liability insurance expense by physician.

6. Supporting documentation for any other direct physician expense. The support needs to detail what makes up the expense and policies governing the amount allowed for physicians.

7. Policies and procedures governing any incentive payments made to the physicians referred to in paragraph 1.

8. Policies and procedures governing amounts paid to physicians for on-call, call-back, and weekend or holiday hours.

9. Policies and procedures governing timekeeping procedures for physicians rendering professional services for the University, and the practice group, if applicable.

10. Provide the number of hours worked weekly by each of the physicians identified in paragraph 1. Do not limit the response to the number of hours expended or expected to be spent at VA; provide the <u>total</u> number of hours worked weekly by the physicians,

including time spent in research, clinical, administrative, and other duties for the university and practice group.

11. Provide the expected percentage of total effort for each proposed physician that will be provided fulfilling the duties and responsibilities specified in the statement of work. Additionally, provide the percentage of total effort that each proposed physician will be expected to spend fulfilling non-VA obligations. This can be expressed as a percentage of the physician's total annual effort.

NOTE: *The response to numbers 10 and 11 may be provided in table format as an example:*

Physician Name	*Average Weekly Hours*	*Percent of Effort at VA*	*Percent of Effort at University*
Dr. Smith	*60*	*50 percent*	*50 percent*

SAMPLE MEMORANDUM

Date:

From: Network Contract Manager

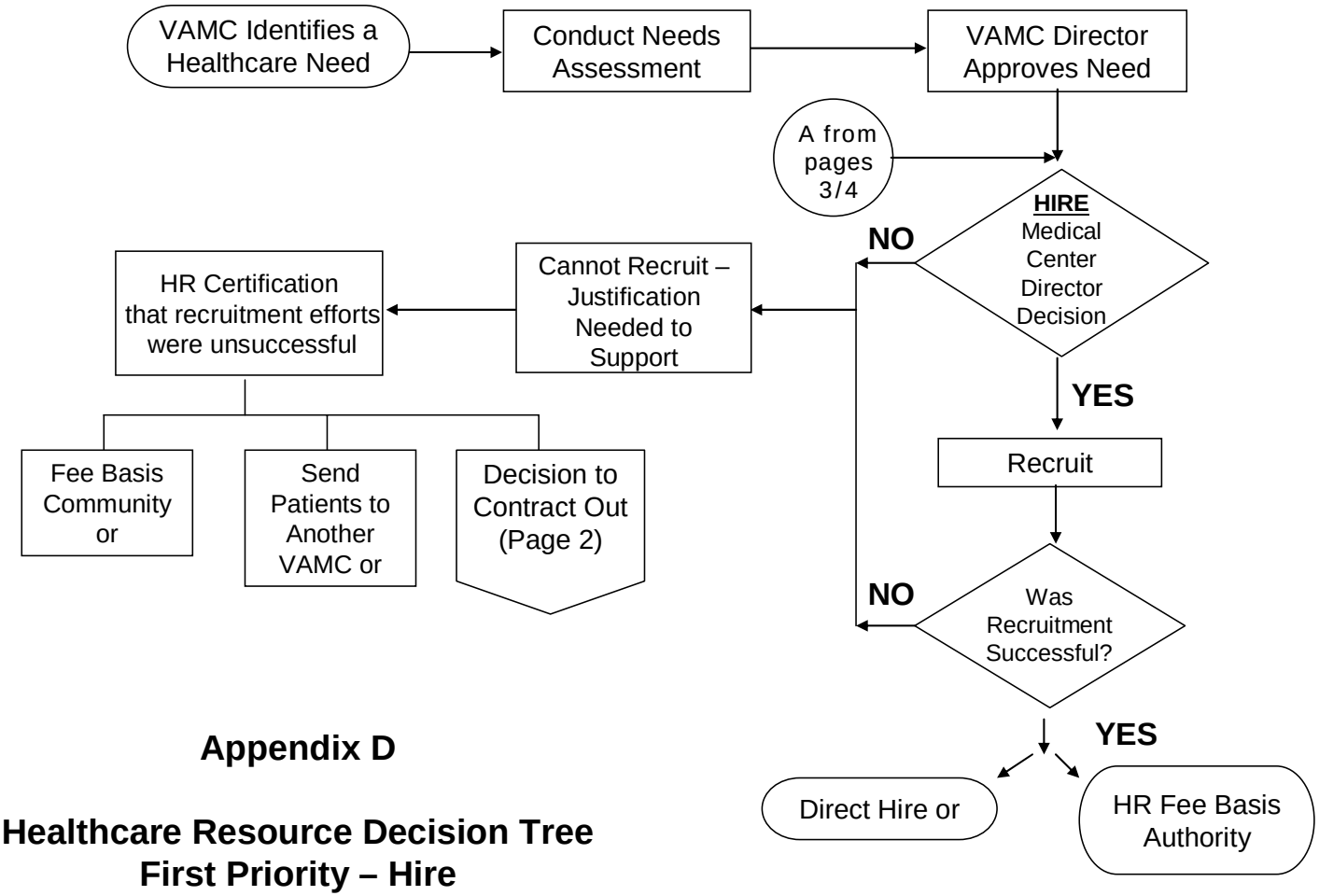
Subj:: Interim Contracting Authority – (Service Being Acquired)

To: Clinical Logistics Office (10F)

In accordance with VA Directive 1663, we hereby request interim contract authority.

1. Authority: Title 38 United States Code (U.S.C.) 8153.
2. Facility name.
3. Type of service: (general surgery, diagnostic radiology, etc.).
4. Quantity of service (# of Full-time Equivalent (FTE) employees or # or procedures).
5. Description of service.
6. Length of authority (up to 180 days).
7. Contractor name (must be an affiliated institution).
8. Contractor address and point of contact, including phone number.
9. Cost (Price).
10. Describe how the interim price was established.
11. VA Medical Center or Network contact person, including phone number.
12. Previous requests for Interim Authority.
13. Is the proposed cost (price) new or a continuation or an old agreement? (yes or no)
14. Is interim needed to prevent a break in service, while a new agreement is being negotiated or is in the process of review and approval? (yes or no) ***NOTE:*** *This includes a pre-award audit from the OIG.*

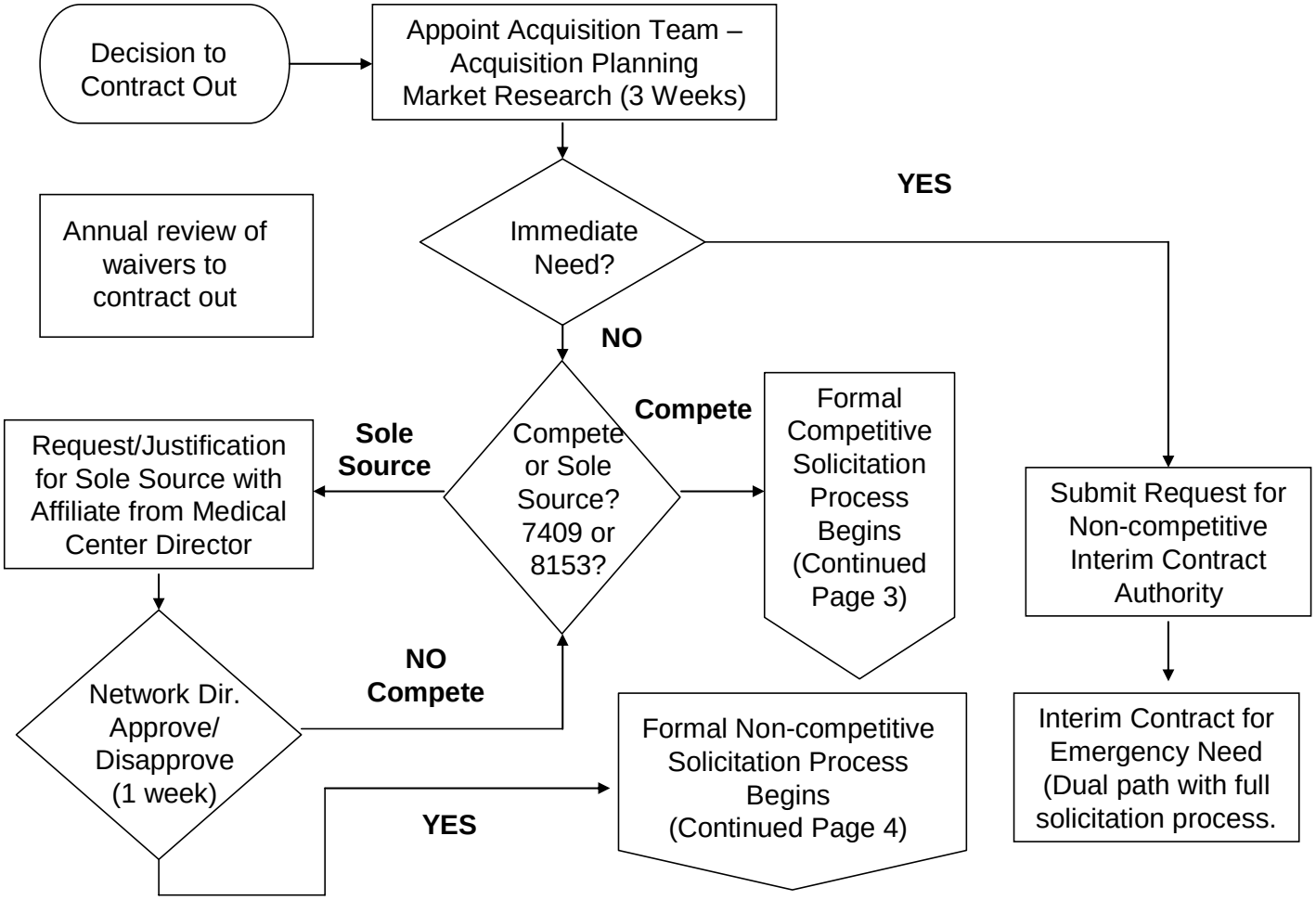
Network Contract Manager's Name and Signature



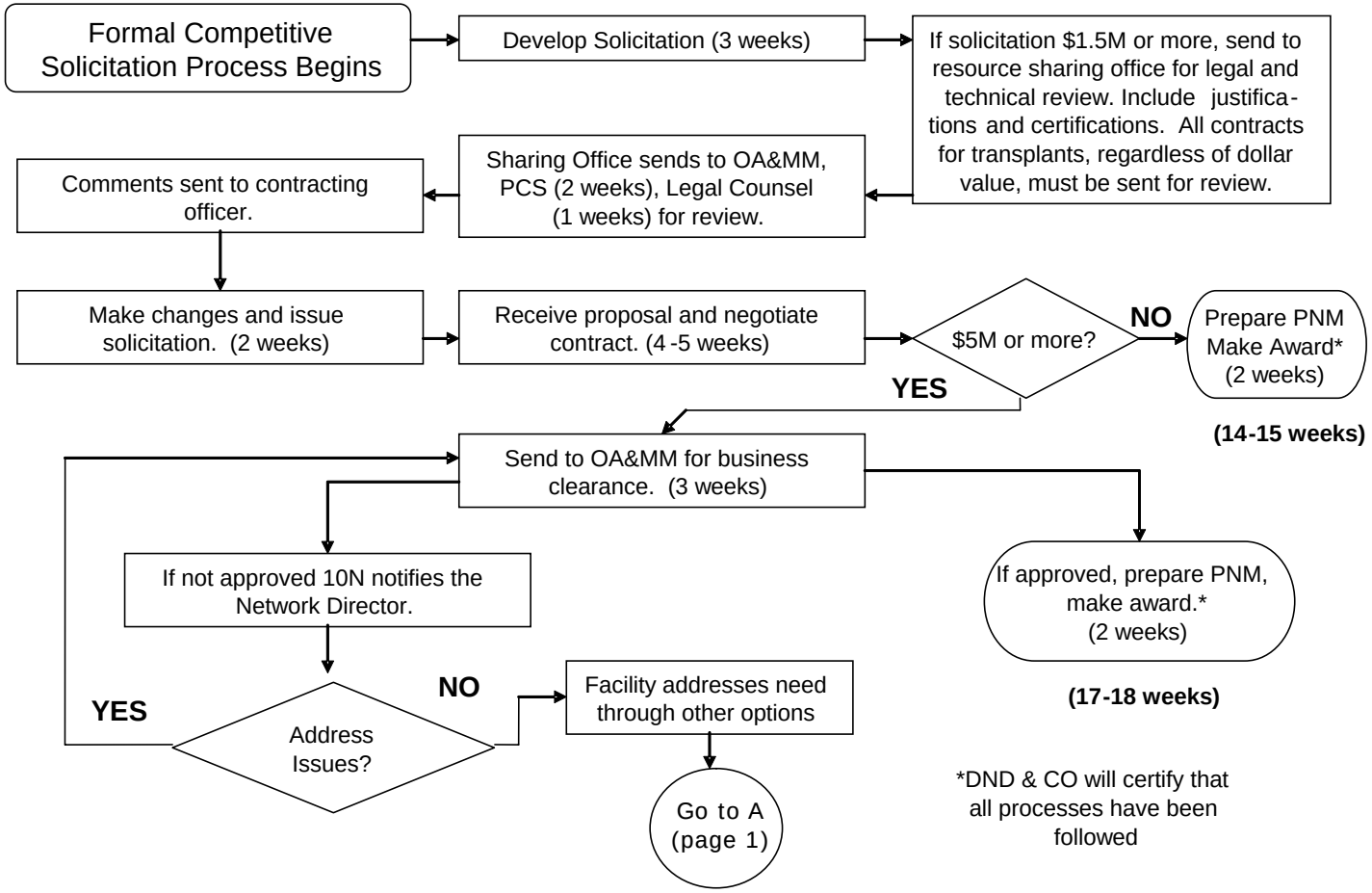
Appendix D

Healthcare Resource Decision Tree
First Priority – Hire
Page 1

Appendix D, Page 2
Healthcare Resource Decision Tree – Decision to Contract Out



Appendix D, Page 3 – Healthcare Resource Decision Tree
Formal Competitive Solicitation Process



Appendix – Page 4 – Healthcare Resource Decision Tree
Formal Non-competitive Solicitation Process