GAO

United States General Accounting Office

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

July 1992

VA HEALTH CARE

Inadequate Controls Over Scarce Medical Specialist Contracts

GAO/HRD-92-114

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-247296

July 29, 1992

The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) operates a nationwide system of medical centers that provide health care services to veterans. Over 100 of these centers contract with outside health care providers to perform specialized medical services in VA facilities. VA refers to these arrangements as scarce medical specialist contracts. Contracting costs for the centers have increased from $17 million in fiscal year 1985 to over $80 million in fiscal year 1991. Radiology and anesthesiology services account for over half of these costs.

In a 1987 congressional hearing that addressed medical centers' contracting activities,[1] VA Inspector General officials testified that six medical centers had paid $1.7 million for contract services that were unneeded or not received. These costs represented almost half of the centers' total medical specialist contract costs. An Inspector General official stated that inadequate contracting procedures were the principal reason for these overpayments and recommended that VA improve its oversight of centers' contracting activities. At your request, we assessed the status of VA's efforts to strengthen management controls.

Results in Brief

VA has not sufficiently improved its management controls to ensure that medical centers are avoiding the types of contracting problems identified in 1987. Although VA officials review all contracts, they do not require medical centers to adequately justify that service quantities are needed and prices are reasonable. When VA contract reviewers recommend changes, they do little to ensure that centers comply. In addition, VA does not make sure that centers use effective procedures to ensure that contractors comply with contract terms. As a result, centers may be purchasing unneeded services at unnecessarily high prices.

[1]Contract Medical Services, hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, One Hundredth Congress, First Session, July 29, 1987, Serial No. 100-23.

Background

VA operates the largest health care delivery system in the United States. Of its 171 hospitals and 240 outpatient clinics, most are organized into 159 medical centers. In fiscal year 1990, VA spent about $11.3 billion providing care to veterans, including about 1.1 million inpatient hospital stays and 22.6 million outpatient visits.

In 1966, the Congress authorized VA to purchase specialized medical services from outside health care providers, when VA determines that it is necessary to do so. VA headquarters and medical center officials told us that they use this authority when they experience recruiting problems due to uncompetitive federal salaries or fewer medical school graduates in some specialties, such as pathology. Medical centers primarily contract for specialty services with affiliated medical schools,[2] which use faculty or other staff to perform services in the centers.

The contracting process involves several steps. First, a medical center decides that it is necessary to contract for scarce medical specialist services. Then, the medical center determines the amount of services needed (generally expressed as number of procedures or hours of service) and estimates the cost. Next, the medical center negotiates a proposed contract with the affiliated medical school.[3] When negotiations are completed, the medical center is required to send the proposed contract, with supporting data, to VA headquarters for review. Once the contract is approved, the medical center awards and administers it.

In May 1991, the Congress enacted the Department of Veterans Affairs Health-Care Personnel Act of 1991 to help VA medical centers recruit and retain physicians by authorizing higher salary levels. This act authorizes VA to increase physicians' salaries under special circumstances, including service in a scarce medical specialty or in a geographic area where VA is experiencing recruiting and retention difficulties.

Scope and Methodology

We reviewed the record of the 1987 hearing, which the Subcommittee on Oversight and Investigations held. We reviewed Inspector General reports that documented contracting problems at six medical centers. (App. I discusses the results of the inspector general's work.) We also reviewed all

[2]Affiliation agreements require medical centers and medical schools to share responsibility for cooperative teaching and training of medical residents in VA facilities, as well as general sharing of medical expertise.

[3]Contracts with affiliated medical schools may be noncompetitive, negotiated contracts; contracts with other private providers must be awarded through competitive bidding.

177 contract proposals involving radiology, anesthesiology, and pathology services, including related documents, that centers submitted to VA headquarters during fiscal year 1990. In addition, we reviewed a sample of 50 fiscal year 1991 radiology, anesthesiology, and pathology contract files.

We reviewed VA policies and procedures for awarding and administering specialized medical contracts. We interviewed VA officials in the Office of Medical Sharing, in various clinical services, and in the Office of Acquisition and Materiel Management; we discussed contracting practices with medical center officials including directors, chiefs of staff, procurement officers, and physicians in various clinical services. We visited 4 centers and conducted telephone interviews with officials at 14 other centers. (App. II lists the centers we contacted.) Our work was done in accordance with generally accepted government auditing standards between October 1990 and February 1992.

VA Controls Over Medical Specialist Contracts Remain Weak

VA has made some changes in its oversight of medical centers' contracting activities. The Inspector General recommended, during the 1987 hearing, that VA (1) require medical centers to adequately justify that service quantities are needed and prices are reasonable and (2) develop criteria for evaluating contract proposals. To improve internal controls, VA revised its policy and now requires medical centers to submit all proposed contracts for review. VA added some staff to administer the review process, but it did not provide criteria for medical centers to use when developing contract proposals or for reviewers to use when evaluating proposals. VA also did not change the requirements for supporting justification that centers must provide as part of the review process.

Before 1991, VA reviewed all new contracts but allowed centers to renew existing contracts without headquarters review. Although medical centers only awarded contracts for a 12-month period, they often renewed them each year. For example, one center we visited had purchased contract anesthesiology services for nearly 20 years using annual contract renewals. Now, VA reviews all contract proposals. Centers may continue to use 12-month contracts or may propose contracts that cover up to 36 months.

Under VA's review process, medical centers submit proposed contracts to VA's Medical Sharing Office, which serves as the clearing house for reviews. The Sharing Office sends copies to the appropriate VA clinical service (medical specialty) for a review of the medical aspects of the

proposed contract. There, the chief of service, who is the highest ranking physician in the specialty area, is responsible for reviewing the appropriateness and necessity of the type and amount of services to be purchased and the price to be paid. At the same time, the Sharing Office sends copies to the headquarters Office of Acquisition and Materiel Management and to the General Counsel's Office for review of technical conformance with Federal Acquisition Regulations and VA Acquisition Regulations, and conformance with prescribed contract formats and VA policy.

VA Provides Little Guidance for Medical Specialist Contracting

VA has not provided formal staffing criteria for medical centers and reviewers to use when developing and evaluating contract proposals. VA's Office of Acquisition and Materiel Management furnishes centers with sample formats for contracting, specifying the clauses and items to be included in a contract. The Medical Sharing Office publishes a "Sharing Medical Resources Program Guide." This guide provides the framework for centers to use in acquiring medical services from outside sources, but does not address medical specialist contracts specifically. The Sharing Office is now developing a revised guide for centers to use when contracting for specialized medical services. A recent draft VA circular specified that thorough cost analysis is expected when developing a contract proposal for specialized medical services, but provided no guidance on the content of this analysis.

During the 1987 hearing, a VA official stated that VA would develop criteria that reviewers and medical centers could use to evaluate work load and staffing relationships for anesthesiology and radiology by September 1988 and September 1989, respectively. Although VA had intended to perform its own studies, it later decided to rely on a larger study being done by the Institute of Medicine. The Institute of Medicine report,[4] issued in September 1991, presents a methodology for developing criteria for the number of physicians required for efficient delivery of medical services. VA officials believe that they can use the study results, along with other available information, to develop general staffing guidelines, but they have not decided how they will proceed. They believe that any staffing criteria that VA develops will only be used as guidelines; therefore, medical center officials and reviewers will continue to use considerable judgment when developing or evaluating contract proposals.

[4]Institute of Medicine, Physician Staffing for the VA, National Academy Press, Washington, D.C., 1991. The Institute was chartered in 1970 by the National Academy of Sciences to examine national health policy issues.

Reviewers told us that they rely primarily on their own judgment, as well as personal knowledge of individual medical centers and the medical marketplace, when evaluating contract proposals. In recent years, several key officials with contract review responsibilities have moved to other positions. Because there are no written criteria, VA must rely on incoming staff to assimilate knowledge of work load and staffing levels.

Centers Not Adequately Justifying Proposed Contracts

Although VA expects centers to submit data supporting (1) the need to use medical specialist contracts and (2) the reasonableness of quantities to be purchased and prices to be paid, VA has not specified support requirements; few centers are providing adequate data when they submit proposed contracts for review. For example, VA policy states that medical specialist contracts may be used only when conventional employment practices have been unsuccessful. But VA does not require centers to provide information on their efforts to recruit physicians to perform specialty services; centers seldom provide recruiting information. As a result, VA reviewers cannot determine whether medical centers tried to recruit physicians before submitting contract proposals. Rather, VA reviewers must assume that medical centers could not recruit medical specialists, an assumption that may not be valid, especially in light of VA's new authority to increase the salaries of medical specialists. (App. III provides additional information on how medical centers' recruiting practices and the new pay authority could affect contract need determination.)

In addition, VA does not require medical centers to submit data justifying the quantity of services to be purchased or the price to be paid. Few medical centers submitted supporting data on their work load or current staffing patterns for the contract proposals we reviewed. Only 18 of the 177 fiscal year 1990 contract files for radiology, anesthesiology, and pathology had documentation supporting the amount of services to be purchased. Most contracts sent to VA also lack justification for the proposed price. Only 20 of the fiscal year 1990 contract files had documentation supporting the price to be paid. We found a comparable lack of supporting data, in reviewing a sample of contract proposals submitted during fiscal year 1991.

Reviewers told us that they generally know the going rate for physicians in their specialty, but may not have specific information about the local costs of specialty services in various parts of the country. They also said that they seek additional information, by phone, when needed.

One of the internal control weaknesses highlighted by the Inspector General in 1987 was that VA centers paid for some contract services that they did not receive. Now, VA requires centers to have, in place, systems to monitor contractors' performance, to ensure the delivery of all required services and the quality of those services. But VA does not ask medical centers to describe their monitoring systems or to provide information about the results of their monitoring efforts for previous contracts. Therefore, VA staff have little knowledge about how medical centers monitor contractors' performance nor any way to make judgments about the effectiveness of medical centers' monitoring activities.

We found that the degree of monitoring varies from one service to another within a medical center and that some monitoring systems were inadequate. At one center, for instance, we observed no specific monitoring in one area where contract doctors are at VA full time. In addition, we found that one service had contract doctors sign log books indicating their presence on a given day. These books, however, do not document the number of hours worked.

Further, when VA officials review proposed contract extensions, they do not require medical centers to submit any information on how well the contractors delivered services under existing contracts. For example, medical centers have quality assurance systems in place but they do not provide the results, which could assist reviewers in assessing the effectiveness of the previous contract.

VA Does Not Ensure That Medical Centers Make Contract Modifications

To date, VA has not instituted follow-up procedures to ensure that required contract modifications resulting from the review process are made. VA allows reviewers to approve contract proposals contingent upon medical centers making certain changes. In 1987, the Inspector General recommended that VA follow up to ensure that medical centers make such contract modifications. However, VA staff do not check the final contracts for compliance.

VA approves many contracts contingent upon certain changes being made. For the most part, these changes are suggested by the Acquisitions Office or the General Counsel and deal with the technicalities of the contract—inclusion of the proper clauses, proper phrasing, specificity of the statement of work and responsibilities of the medical center and the contractor. When there are questions about contract costs or services to be provided, they are generally the concern of the clinical services

reviewing the contract and are often resolved through informal contacts between the VA service and the medical center staff.

VA provided contingent approval for 129 of 177 radiology, anesthesiology, and pathology contract proposals for fiscal year 1990. VA requested but did not require medical centers to provide evidence that they had made the recommended changes. The centers provided such documentation to VA in only a few cases. In 85 of the 129 cases that had contingent approval, executed contracts were not in the files so there was no way for VA to determine whether changes had been made. In the other 44 cases, all suggested changes had been made for 21 cases; some, but not all, changes had been made for 6 cases; and no changes had been made in 17 cases.

VA's required contract modifications frequently involved contract terms and specifications, which, if not made, could adversely affect centers' ability to effectively administer the contracts. For example, in 1987 the Inspector General recommended that medical centers recover overpayments made to certain contractors. However, the medical centers in question could not recover any money. According to the Inspector General, the Miami medical center overpaid $480,000. But the medical center could not press for a refund because the contract statement of work did not describe adequately and specifically the characteristics of the work to be done.

Conclusions

VA needs to improve its oversight of medical centers' proposed scarce medical specialist contracts. Currently, VA cannot adequately identify medical centers that are experiencing the types of contracting problems that the Inspector General reported in 1987. Implementation weaknesses include a lack of data on work load, staffing patterns, hiring practices, and salary structures as part of the justifications supporting contract proposals as well as inadequate criteria for developing and evaluating contract proposals. Without better data and evaluation criteria, reviewers have to base decisions on their individual knowledge of these factors or to request, on a case by case basis, data on these factors for the more than 100 centers submitting contract proposals. In addition, reviewers' efforts will be ineffective if centers fail to implement required contract modifications.

Recommendations

We recommend that the Secretary of Veterans Affairs direct the Chief Medical Director to require medical center directors to justify, as part of

their contract proposals, that (1) physicians who perform specialty medical services cannot be hired using conventional employment practices, (2) the quantity of services purchased and prices paid for them are reasonable, and (3) effective controls are in place to monitor contractors' performance.

To assist medical centers and contract reviewers, the Secretary should direct the Chief Medical Director to develop general guidelines for evaluating the reasonableness of quantities and costs of proposed services. The Chief Medical Director should direct reviewers to ensure that centers make all required changes, when contracts are approved on a contingent basis.

Agency Comments

In commenting on a draft of this report, VA agreed with our conclusions and recommendations (see app. IV). In a July 8 meeting, VA staff expressed concern about the use of the term "criteria" in our recommendation that VA develop criteria for evaluating the quantities and costs of contract services. VA officials said that "criteria" implied uniform application across the system. We have changed the wording of our recommendation to make clear that it is intended to help ensure that both medical center personnel who develop scarce medical specialist contracts and those who review those contracts have adequate guidance to effectively perform their responsibilities. We recognize that these officials' judgment will continue to play a role in determining medical centers' specific needs.

The Secretary of Veterans Affairs expressed his commitment to the improvement of VA's scarce medical specialist contracting activities. He stated that VA had made some progress in improving the oversight of these contracts, but he recognized there are still substantial weaknesses. The Secretary pointed out that the Inspector General recently began a thorough review of scarce medical specialist contracts at the medical center level, and he has directed the Inspector General to explore ways to improve VA headquarters' oversight. In addition, the Secretary noted that VA will explore mechanisms for additional control and oversight at the regional level. If necessary, in light of these reviews, VA will change policies to ensure tighter controls over the procurement of scarce medical specialist services. The Secretary also provided technical comments, which we incorporated as appropriate.

Unless you publicly announce its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send copies to the Secretary of Veterans Affairs and interested congressional committees. We will make copies available to others upon request. If you have any questions regarding this report, please contact me at (202) 512-7101. Major contributors to this report are listed in appendix V.

Sincerely yours,

David P. Baine

David P. Baine
Director, Federal Health Care
Delivery Issues

Contents

Abbreviation

VA Department of Veterans Affairs

VA Inspector General Reported Contracting Problems in 1987

Between 1984 and 1987, VA's Inspector General issued several reports that discussed contracting problems associated with purchase of anesthesiology and radiology services from affiliated universities. The Inspector General's work involved detailed reviews of records and service logs at several medical centers. The reports formed the basis for a hearing before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs. The Inspector General reports included:

Audit of VA Medical Center West Haven, Connecticut, Report No: 5R1-F03-007, October 26, 1984.

Audit of John L. McClellan Memorial Veterans' Hospital Little Rock, Arkansas, Report No: 6R6-F03-002, October 10, 1985.

Audit of VA Medical Center Miami, Florida, Report No: 6R3-F03-111, September 12, 1986.

Audit of VA Medical Center Palo Alto, California, Report No: 7R8-F03-012, November 13, 1986.

Audit of VA Medical Center Birmingham, Alabama, Report No: 7R3-F03-009, December 9, 1986.

Audit of VA Medical Center Baltimore, Maryland, Report No: 7R2-F03-045, March 13, 1987.

Audit of Selected Aspects of VA's Program for Sharing Scarce Medical Resources, Report No: 7AM-A99-089, July 15, 1987.

The reports noted several problems with VA's award and administration of scarce medical specialist contracts. Overall, the reports found that medical centers

- awarded contracts to purchase more anesthesiology and radiology services than were needed,
- paid for services that they did not receive in accordance with contract terms, and
- had not established controls to ensure that services contracted for were required and that contractor performance and billings complied with contract terms.

VA Inspector General officials reported that six medical centers paid about $1.7 million for medical specialist services that were either not needed or not provided, because of poor controls and inadequate evaluation and monitoring of contracts. The Inspector General identified this problem by analyzing work load and staffing data available at these medical centers.

At the Miami medical center, for instance, the Inspector General estimated that from 1983 to 1986 the medical center paid the University of Miami for anesthesiology and radiology services that were never delivered because of unclear specifications and lack of controls to ensure contractor performance. The Inspector General found that the medical center paid for nighttime and weekend on-call coverage whether services were provided or not. VA Inspector General officials testified that controls had not been established to ensure that contractor performance and billings complied with contract terms.

The Inspector General also estimated that the Little Rock medical center overpaid $232,000 to the University of Arkansas because of inadequate attention to contract monitoring and contractor performance. The contract called for services to be provided equally by faculty in four pay levels, but nearly three-fourths of the regular duty hours were worked by faculty in the lower pay levels. In addition, the medical center paid the full cost for standby, on-call services by a radiologist who was splitting his time between VA and the university.

In addition, the Inspector General questioned, in 1987, whether the costs of some radiation therapy contracts were reasonable. The Inspector General found great disparity among 17 medical centers in average annual costs per patient, ranging from a low of $141 to a high of $4,200, based on reported work load. VA responded that the reported work load figures were inconsistent with one another—some medical centers might report new patients only (which represents most of the contract cost) while others might report all patients treated, or total treatments. Thus VA could not determine the actual annual cost per patient. Because of these inconsistencies, the Inspector General concluded that VA did not have sufficient information to determine reasonableness of cost.

The Inspector General also found that inadequate contract terms could adversely affect medical centers' ability to administer contracts effectively. For example, in the Miami case, according to the Inspector General, the medical center overpaid $480,000. But the medical center

could not press for a refund because the contract statement of work did not describe adequately and specifically the characteristics of the work to be done.

Since the 1987 hearing, the Inspector General has issued additional reports that discussed contracting problems at medical centers. These include:

Audit of John L. McClellan Memorial Veterans' Hospital Little Rock, Arkansas, Report No: 8R6-F03-027, January 21, 1988.

Audit of VA Medical Center Durham, North Carolina, Report No: 9R3-F03-006, November 1, 1988.

Audit of VA Medical Center Seattle, Washington, Report No: 9R8-F03-069, May 12, 1989.

Medical Centers We Contacted

Medical Centers Visited

Baltimore, Maryland
Durham, North Carolina
Palo Alto, California
San Antonio, Texas

Medical Centers Telephoned

Albuquerque, New Mexico
Birmingham, Alabama
Cincinnati, Ohio
Cleveland, Ohio
Jackson, Mississippi
Little Rock, Arkansas
Long Beach, California
Memphis, Tennessee
Philadelphia, Pennsylvania
Portland, Oregon
Salt Lake City, Utah
St. Louis, Missouri
Syracuse, New York
West Los Angeles, California

Medical Center Recruiting Practices Affect Contract Need Determination

VA medical centers may use contracts whenever they deem appropriate. VA's guidance states that scarce medical specialist contracts may be used only when conventional employment practices have been unsuccessful. This guidance, however, does not require centers to submit evidence of their inability to recruit medical specialists as a prerequisite to contracting.

VA Salaries May Affect Recruiting Efforts

Some medical center officials believe that it is impossible to hire physicians in certain specialties because VA salaries are too low. Three of the medical centers we visited had not tried to recruit physicians in certain specialties for several years. Over the last 4 years, one medical center annually contracted for anesthesiology services equivalent to 5-1/4 full-time employees but did not attempt to recruit anesthesiologists during that time.

Under the Department of Veterans Affairs Health-Care Personnel Act of 1991, VA has the authority to increase salaries for scarce medical specialists. The increases would enable VA to pay salaries similar to those paid at affiliated medical schools. This new law provides for additional physician pay for such factors as service in a scarce medical specialty (up to $40,000), service in specific geographic locations (up to $17,000), and exceptional qualifications (up to $15,000).

With approval of the Secretary of Veterans Affairs a physician's total salary could be increased to $200,000. Base pay plus special pay can exceed the federal government's Executive Level I pay, currently $143,800, with the approval of the Secretary of Veterans Affairs. VA has decided that the pay of a Chief of Staff will not exceed this level, according to a VA official. Medical center directors may approve salary levels up to $125,000.

Medical centers have used the act to increase pay for physicians. One center, according to its director, has canceled plans for a radiology contract due to the center's increased ability to pay higher salaries and thus attract physicians, which it could hire directly.

Affiliations With Medical Schools May Affect Recruiting

A medical center's relationship with its affiliated medical school may also affect its recruiting and contracting practices. For instance, a pathologist who had worked at a VA medical center for many years under a scarce medical specialist contract retired from his position as a faculty member at the affiliated medical school. After his retirement, the medical center

lowered contract requirements by one full-time employee equivalent and began to recruit for a full-time VA employee pathologist.

A VA official told us that centers sometimes feel that they have made a commitment to their affiliated medical schools by entering into a scarce medical specialist contract. A medical school may hire additional staff to fulfill its contract obligations, implicitly committing to a long-term employment relationship; sometimes these are tenured positions. Even though a scarce medical specialist contract is only awarded for a 12-month period, medical centers we visited had contracted for specialty services for as long as 20 years using annual contract renewals.

Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 17, 1992

Mr. David P. Baine
Director, Federal Health Care
Delivery Issues
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Baine:

We have reviewed GAO's draft report, VA HEALTH CARE: Inadequate Controls Over Medical Specialist Contracts (GAO/HRD-92-114) and agree with your conclusions. While the Department has made some progress in improving the oversight of these contracts, we recognize there are still substantial weaknesses in the program. I am committed to making improvements in this program.

The GAO review identified weaknesses, particularly in VA Central Office oversight of these contracts. The Inspector General recently began a thorough review of scarce medical specialist contracts at the medical center level, and I have directed that the IG review also address ways to improve Central Office oversight. In addition, we will explore mechanisms for additional control and oversight at the Regional level. If necessary, in light of these reviews, we will change our policies to assure tighter controls over the procurement of scarce medical specialist services.

The enclosure summarizes changes to the draft report that were suggested at the July 8 meeting between your staff and ours. Thank you for the opportunity to comment.

Sincerely yours,

Edward J. Derwinski

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT, **VA HEALTH CARE: Inadequate Controls Over Medical Specialist Contracts**
(GAO/HRD-92-114)

GAO recommends that I require the Chief Medical Director to develop guidelines to require VA medical center directors to justify, as part of their contract proposals, that

(1) physicians to perform specialty medical services cannot be hired using conventional employment practices,
(2) the quantity of services purchased and prices paid are reasonable, and
(3) effective controls are in place to monitor contractors' performance.

I concur with the above recommendations.

In discussing contracting activities, the report should note that:

a. VHA management has eliminated contract renewals in the field.
b. VHA Central Office officials now review all contracts, new or renewals.
c. VHA has added additional staff to the scarce medical specialist program within the Medical Sharing Office for more timely and thorough review of contracts.

Nevertheless, we recognize that these steps have had limited effect on oversight of contracting activities.

In closing the report states:

To assist medical centers and contract reviewers, the Secretary should direct the Chief Medical Director to develop criteria for evaluating the reasonableness of quantities and costs of proposed services.

Based on the July 8, 1992, meeting between VA and GAO officials, we understand that recommendation will be changed to read:

To assist medical centers and contract reviewers, the Secretary should direct the Chief Medical Director to develop general guidelines evaluating the reasonableness of quantities and costs of proposed services.

Major Contributors to This Report

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