Department of Veterans Affairs

Office of Inspector General

EVALUATION OF VA MEDICAL CENTER CLINICAL SERVICES CONTRACTS WITH MEDICAL SCHOOLS

VA medical centers need additional guidance on using commercial items contracts to purchase clinical services.

Report No. 9R8-E11-008
Date: October 30, 1998

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Acting Under Secretary for Health (10)

Evaluation of VA Medical Center Clinical Services Contracts with Medical Schools

1. The Office of Inspector General performed an evaluation of VA medical center (VAMC) practices in contracting for clinical services with affiliated medical schools. The evaluation focused on determining if VAMCs had developed any new contracting practices that were questionable or inappropriate, such as using Intergovernmental Personnel Act assignments (IPAs) as a substitute for scarce medical specialist (SMS) contracts, a practice that was identified by our 1997 audit of IPAs. As a result of our initial findings on that audit, in August 1996 the Veterans Health Administration (VHA) issued guidance directing VAMCs not to use IPAs to obtain clinical services. As part of the evaluation, we followed up on VAMC implementation of this guidance. To meet the evaluation objectives, we reviewed noncompetitive clinical services contracts and IPAs at VAMCs San Francisco, Palo Alto, Pittsburgh, and Minneapolis.

2. The evaluation found that some VAMCs continued to use IPAs as a substitute for SMS contracts. Our review of 25 non-research IPAs at the 4 VAMCs found that all 25 represented an inappropriate use of the IPA authority. Of the 25 IPAs, 18 (72 percent) were established after the issuance of the August 1996 guidance on IPAs. During the evaluation, we informed VHA management of the continuing inappropriate use of IPAs. In response, VHA management initiated immediate corrective action, issuing a memorandum that forcefully directed VAMCs to terminate all inappropriate IPAs by June 30, 1998. Based on this corrective action, we consider this issue to be resolved.

3. The evaluation also found that some VAMCs had begun using commercial items (CI) contracts as a substitute for SMS contracts. Unlike SMS contracts, CI contracts do not require cost or pricing (C/P) data to support proposed prices. Because of this, there is a risk that VAMCs could overpay for services. Three of the four VAMCs evaluated had begun using CI contracts. These contracts fell into two categories -- procedure-based and staff-based. Our review of two procedure-based contracts found no deficiencies because procedure prices were set using Medicare rates as the ceiling. When prices are based on Medicare rates there is no need for C/P data because these rates are, by definition, considered to be reasonable. Our review of the staff-based contracts did not identify any overcharges. However, because C/P data is not required on these contracts there is a risk that VAMCs could: (1) accept prices without any data to support price reasonableness; (2) accept prices that are based on the average salary for physicians working in the medical school department that has the contract instead of on the

salaries of the physicians actually working under the contract; and/or (3) be charged for unallowable administrative, fringe benefits, and other costs.

4. During the evaluation, VHA officials expressed agreement with our concern about the risks associated with using CI contracts and they agreed that guidance was needed to address this issue. We recommended that VHA follow through with issuing guidance that would (1) emphasize the importance of obtaining sufficient information to insure that prices paid on noncompetitive CI contracts are reasonable and (2) recommend the use of C/P data as the benchmark for price reasonableness for staff-based contracts and Medicare rates as the benchmark for procedure-based contracts. The Acting Under Secretary for Health concurred in principle with the recommendation and provided an acceptable implementation plan. We consider all evaluation issues resolved and we will follow up on the completion of planned corrective actions.

For the Assistant Inspector General for Auditing

(Original signed by:)
DAVID SUMRALL
Director, Seattle Audit Operations Division

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Results and Recommendations

Additional Policy Guidance Would Reduce the Risks Associated with Using Noncompetitive Commercial Items Contracts to Purchase Clinical Services

The evaluation identified two issues that warranted Veterans Health Administration (VHA) management attention. First, some VA medical centers (VAMCs) continued to use Intergovernmental Personnel Act assignments (IPAs) as a substitute for scarce medical specialist (SMS) contracts, despite VHA's August 1996 direction to discontinue this practice. Second, some VAMCs had begun using commercial items (CI) contracts as a substitute for SMS contracts. Because CI contracts do not require cost or pricing (C/P) data to support proposed prices, there is a risk that VAMCs could overpay for services. During the evaluation, we discussed the IPA issue with VHA officials and they immediately initiated corrective action. In December 1997, VHA directed VAMCs to terminate all inappropriate IPAs by June 30, 1998. Based on this corrective action, we consider this issue to be resolved. VHA also agreed that guidance was needed to address the risks associated with CI contracts. We recommend that VHA follow through with issuing guidance aimed at insuring that VAMCs obtain reasonable prices on CI contracts.

Background

Since 1993, the OIG has performed three audits pertaining to the practices that VAMCs follow in procuring SMS services from their affiliated medical schools. Scarce medical specialists are medical professionals who are difficult for VA to recruit and retain. Our 1993 Audit of Scarce Medical Specialist Contracts with Medical Schools found that VAMC contracting practices generally did not comply with VA policies and that VAMCs paid excessive charges on most contracts (Report No. 3R8-A99-055; March 26, 1993). We recommended that VHA provide VAMCs with better procedural guidance on SMS contracts and monitor VAMC compliance with this guidance. Most importantly, VHA needed to enforce the requirement that noncompetitive contracts must be based on C/P data.

VHA issued guidance and provided training to address the audit issues. Our 1995 Follow-up Review of Audit of Scarce Medical Specialist Contracts found that VAMC contracting practices had significantly improved, and we concluded that the SMS contracting program was generally well-managed and substantially in compliance with applicable laws, regulations, and policies (Report No. 5R8-A05-057; May 10, 1995).

However, in about 1994-1995, some VAMCs began using IPAs as a means of obtaining SMS services and thereby avoiding SMS contracting requirements. Before then, IPAs had mainly been used to temporarily hire medical school staff to work on VA clinical research projects. Our Audit of VA Medical Center Use of Intergovernmental Personnel Act Assignments found that IPAs used to support research activities were appropriate but that IPAs used to obtain services did not meet policy requirements and did not provide the procurement integrity and pricing

protections built into the SMS contracting policies and procedures (Report No. 7R8-A19-044; February 27, 1997). As a result of inappropriately using IPAs, VAMCs paid more for services than they would have paid using properly negotiated SMS contracts. To address the audit issues, in August 1996 the Under Secretary for Health sent all VAMCs a memorandum emphasizing that IPAs should not be used as a substitute for SMS contracts and directing that all IPAs be reviewed to insure full compliance with regulations.

Results of Review

VAMCs Continued to Use IPAs as a Substitute for SMS Contracts

Inappropriate IPAs. All 25 of the non-research IPAs we reviewed represented an inappropriate use of the IPA authority. These IPAs were used to obtain clinical services that would normally be obtained through SMS contracts or by hiring the clinician as a part-time VA employee. Of the 25 IPAs, 18 (72 percent) were established after the issuance of VHA's August 1996 guidance directing VAMCs not to use IPAs as a substitute for SMS contracts.

VHA Corrective Action. During the evaluation, we informed VHA management of the continuing inappropriate use of IPAs. In response, VHA management initiated immediate corrective action, issuing a memorandum that forcefully directed VAMCs to terminate all inappropriate IPAs no later than June 30, 1998 (December 18, 1997, memorandum from the Under Secretary for Health to all VAMCs). In addition, management at all four VAMCs we visited agreed to terminate the inappropriate IPAs identified by our evaluation.

VAMCs Used CI Contracts as a Substitute for SMS Contracts

Trend Toward Using CI Contracts. Some VAMCs had begun inappropriately using CI contracts as a means of avoiding SMS contracting requirements, particularly the requirement to obtain certified C/P data. The Federal Acquisition Regulations (FAR) define commercial items (sometimes called commercial services) as services that are offered and sold competitively in the commercial marketplace based on established catalog or market prices (FAR 2.101). When contracting officers award contracts under the CI authority, they are not required to obtain C/P data because the information needed to determine price reasonableness is generally readily available (such as from catalogs or price lists).

The emerging trend toward using CI contracts to obtain clinical services developed after the passage of the Veterans Health Care Eligibility Reform Act of 1996. This legislation allowed VA to enter into contracts with any healthcare provider, and the legislation encouraged the use of commercial services contracts (following the FAR definition of "commercial services"). To implement the legislation, VHA issued VHA Directive 97-015 (March 12, 1997) which stated that the term "commercial services" includes "medical or professional services as well as other services." This guidance allowed VAMCs to use noncompetitive CI contracts to procure the types of services that had traditionally been obtained through noncompetitive SMS contracts.

Of the four VAMCs we visited, three -- Palo Alto, Pittsburgh, and Minneapolis -- had begun using CI contracts as a substitute for SMS contracts.[1] Of the 41 noncompetitive contracts at these 3 VAMCs, 17 (41.4 percent) valued at $4.7 million were CI contracts awarded since 1996. All 17 contracts were for the types of clinical services that traditionally would have been obtained through SMS contracts.

We reviewed 9 of the 17 CI contracts. The nine contracts fell into two categories -- two were procedure-based and seven were staff-based. As the terms suggest, under procedure-based contracts the VAMC pays the medical school for specific procedures and under staff-based contracts the VAMC pays the school for the services of school employees who perform the services at the VAMC. Of the nine CI contracts reviewed, four replaced prior SMS contracts. All four of these were staff-based contracts.

Risk of Using Staff-Based CI Contracts. We concluded that the two procedure-based CI contracts were properly awarded and did not present significant risk of overcharges. Under both contracts, procedure prices were set using Medicare rates as the ceiling. Medicare rates are, by definition, considered to represent reasonable prices.

Our reviews of the seven staff-based CI contracts did not identify any excessive charges. However, we believe that the use of staff-based CI contracts presents a risk that does not exist with either procedure-based CI contracts or staff-based SMS contracts. For procedure-based CI contracts, C/P data is generally not necessary because Medicare rates are readily available as a measure of price reasonableness. For staff-based CI contracts there is no measure similar to Medicare rates. The only reliable measure of price reasonableness is verifiable C/P data that shows the salary and benefits costs that the medical school incurs to provide the staff. This data is required for staff-based SMS contracts.

For the seven staff-based contracts, VAMC contracting staff did obtain some salary cost data from the schools, but the contracting staff did not independently verify the accuracy of the data. Instead, to determine if the salary cost data was reasonable, contracting staff at two of the VAMCs (Pittsburgh and Minneapolis) compared the data provided by the schools to faculty physician salary data shown in a publication entitled Report on Medical School Faculty Salaries prepared by the Association of American Medical Colleges. If the proposed contract prices were in line with salaries reported in this publication, then the contracting staff accepted the offered prices. At VAMC Palo Alto the contracting staff accepted the medical school's reported costs without verifying them.

We examined medical school salary and benefits records and concluded that prices charged on all seven contracts were in line with the schools' costs. However, even though we identified no overcharges on these contracts, we believe that because C/P data is not required for staff-based

[1] VAMC San Francisco did not have any CI contracts but instead had used IPAs as a substitute for SMS contracts. To illustrate, the VAMC had terminated a longstanding anesthesiology services SMS contract and had placed the contract employees on IPAs.

contracts there is a risk that three problems identified by ouur 1993 audit of SMS contracts could recur:

- VAMCs could accept prices without any data to support price reasonableness.
- Contract prices could be based on the average salary for physicians working in the medical school department that has the contract. The school could then make an unwarranted profit by assigning to the VA contract junior physicians whose salaries are less than the department average.
- Medical schools could charge VA for unallowable administrative costs, fringe benefits, and other costs that are not truly part of the costs medical schools incur to provide the contract services.

VHA Corrective Action. During the evaluation, MSO officials expressed agreement with our concern about the risks associated with using noncompetitive CI contracts. They indicated that they would issue additional guidance for VAMCs to use in awarding these contracts. This guidance will emphasize the importance of obtaining sufficient information to insure that contract prices are reasonable. The guidance will recommend the use of C/P data and Medicare rates as the benchmarks for determining price reasonableness.

Conclusion

During the evaluation VHA took action to address the continued inappropriate use of IPAs and initiated action to address the emerging trend toward the inappropriate use of CI contracts. To help insure that clinical services are procured at the best possible prices, VHA should follow through with the issuance of the proposed guidance on the proper use of CI contracts.

For More Information

- The evaluation objectives, scope, and methodology are discussed in Appendix I, page 6.

Recommendation 1

We recommend that the Acting Under Secretary for Health follow through with issuing guidance that will (1) emphasize the importance of obtaining sufficient information to insure that prices paid on noncompetitive CI contracts are reasonable and (2) recommend the use of C/P data as the benchmark for price reasonableness for staff-based contracts and Medicare rates as the benchmark for procedure-based contracts.

Acting Under Secretary for Health Comments

The Acting Under Secretary for Health concurred in principle with the recommendation.

Implementation Plan

VHA will send VAMCs guidance on the steps to be taken in negotiating CI contracts with affiliates. These steps will include requesting relevant C/P data, researching market prices, and maintaining documentation supporting the outcome of contract negotiations and the rationale for actions taken. The guidance will be issued by April 30, 1999. (See Appendix II, pages 7-8, for the full text of the Acting Under Secretary's comments and implementation plan.)

Office of Inspector General Comments

The Acting Under Secretary for Health concurred in principle with the recommendation and provided an acceptable implementation plan. We consider the recommendation to be resolved and will follow up on the completion of planned corrective actions.

Objectives, Scope, and Methodology

The objectives of our evaluation were to determine: (1) if VAMCs had terminated inappropriate IPAs in accordance with VHA's August 1996 direction; and (2) whether VAMCs had developed any new questionable practices for noncompetitive procurement of clinical services from affiliated medical schools or related entities, such as faculty physician practice groups. To meet these objectives, we performed onsite evaluations at VAMCs San Francisco, Palo Alto, Pittsburgh, and Minneapolis. These VAMCs had a total of 25 non-research IPAs and a total of 46 noncompetitive clinical contracts. We reviewed pertinent information on all 25 IPAs and we obtained and reviewed C/P data for 19 of the 46 contracts. During our onsite reviews we discussed contracting practices with VAMC staff and management.

In addition to our onsite reviews, we reviewed pertinent VA policies, legislative history, federal procurement rules, and program management reports. We discussed program operations with officials of the MSO, VA's Office of Acquisition and Materiel Management, and the Office of General Counsel. The evaluation was done in accordance with generally accepted government auditing standards for staff qualifications, independence, and due professional care; field work standards for planning, supervision and evidence; and reporting standards for performance audits.

VHA does not maintain reliable centralized databases on either clinical contracts or IPAs. The MSO has attempted to maintain a database of contracts awarded by VAMCs. However, this database depends on self-reporting by VAMCs, and we found it to be inaccurate. To illustrate, for Fiscal Year 1997 the database showed that 84 VAMCs had reported 491 contracts valued at $86.5 million. However, we contacted 10 VAMCs that were not shown in the database and found that these VAMCs had a total of 133 contracts valued at $34.5 million. Given the inaccuracy of the reported data, we were unable to reliably determine the total number and value of VAMC clinical contracts. Similarly, we could not determine the number and value of active IPAs because VAMCs are not required to report their use of IPAs and there is no database listing all IPAs.

Acting Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: October 7, 1998

From: Acting Under Secretary for Health (10/105E)

Subj: Follow-up Action on OIG Draft Report, *Evaluation of VA Medical Center Clinical* Services Contracts With Medical Schools, (Project No. 8R8-047)

To: Assistant Inspector General for Auditing (52)

1. The Veterans Health Administration (VHA) provided comments to you on the subject report on August 10, 1998. As part of our comments we nonconcurred with your recommendation that VHA issue guidance that requires that all staff-based clinical contracts must be awarded under the scarce medical specialist contracting authority and must be supported by certified cost and pricing (C/P) data, and that procedure-based commercial item contracts be used only if Medicare rates are used as the ceiling for procedure prices. Our reasons for not concurring were that the need for the recommendation was not founded based on the report findings and that it unduly restricts the flexibility intended by Congress in enacting the changes for the use of commercial item contracts under 38 USC 8153.

2. Members of your staff, VHA, the Office of Acquisition and Materiel Management, the General Counsel and the OIG Counsel met on September 1, 1998, to discuss how to resolve the nonconcurrence. As a result of that meeting you changed the recommendation to the following:

> We recommend that the Under Secretary for Health follow through with issuing guidance that will (1) emphasize the importance of obtaining sufficient information to insure that prices paid on noncompetitive CI contracts are reasonable, and (2) recommend the use of C/P data as the benchmark for price reasonableness for staff-based contracts and Medicare rates as the benchmark for procedure-based contracts.

VHA concurs in principle with this change and is proposing the following actions in response to the modifications in the recommendation. VHA will publish further guidance to the field on steps to be taken in negotiating commercial item contracts with affiliates, specifically to request relevant cost/pricing information to the extent required by the Federal Acquisition Regulations; the need to thoroughly research market prices from sources such as Medicare fee schedules and professional society survey

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Acting Under Secretary for Health Comments, Continued

2. Assistant Inspector General for Auditing (52)

information; and a requirement to maintain complete documentation in the contract folder supporting the outcome of the negotiation and the rationale for actions taken.

3. We believe the change in the recommendation and our proposed action in response to the recommendation resolves the nonconcurrence. We anticipate issuing the additional guidance by the end of April 1999. If you have any questions, please contact Paul C. Gibert, Jr., Director, Management Review and Administration Service (105E). Office of Policy and Planning, at 273-8360.

(Original signed by:)
Thomas L. Garthwaite, M.D.

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