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VA HEALTH CARE

Inadequate Controls Over Scarce Medical Specialist Contracts

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA's) use of contracts to purchase scarce medical specialist services. More than 100 VA medical centers contract with outside providers to perform specialty services. These contracts are negotiated primarily with affiliated medical schools. Centers' contracting costs have increased from $17 million in fiscal year 1985 to over $80 million in fiscal year 1991. Radiology and anesthesiology services account for the majority of these costs.

As you know, VA's Inspector General presented his assessment of six medical centers' contracting activities to this Subcommittee during a 1987 hearing.[1] He found that the centers had paid $1.7 million for contract services that were unneeded or not received. He cited inadequate contracting procedures as the principal reason for centers' overpayments and recommended that VA improve its oversight of centers' contracting activities.

At your request, we assessed the status of VA's efforts to make the changes it had promised in 1987 to strengthen its management of these contracts. In doing this, we reviewed VA policies and procedures concerning scarce medical specialist contracts and discussed them with a wide range of VA staff. In addition, we visited 4 medical centers and surveyed 14 others by telephone to see how the policies and procedures were implemented. We also reviewed each of VA's contracts for radiology, anesthesiology, and pathology services that medical centers proposed during fiscal year 1990, as well as a sample of fiscal year 1991 contracts for these services. We met with Inspector General officials to discuss the preliminary results of their reviews of scarce medical specialist contracts that are now underway at selected medical centers.

RESULTS IN BRIEF

As we recently reported to you,[2] VA has not sufficiently improved its management controls to ensure that medical centers are avoiding the types of contracting problems identified in 1987. Although headquarters officials review all contracts, they do not require medical centers to justify adequately that service quantities are needed and prices are reasonable. When VA contract

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[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.

[2]VA Health Care: Inadequate Controls Over Scarce Medical Specialist Contracts, (GAO/HRD-92-114, July 29, 1992).

reviewers recommend changes, they do not ensure that centers make those changes. In addition, VA does not make sure that centers use effective procedures to see that contractors adhere to contract terms. As a result, centers are still purchasing unneeded services at unnecessarily high prices.

Given the large increase in centers' contracting activities, we believe that VA should quickly address these issues. To do this, we recommended 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 are reasonable, and (3) effective controls are in place to monitor contractors' performance. To assist medical centers and contract reviewers, VA should develop general guidelines for evaluating the reasonableness of quantities and costs of proposed services. Lastly, reviewers should ensure that centers make all required changes when contracts are approved on a contingent basis.

Now, I would like to describe how VA centers award scarce medical specialist contracts and highlight the major weaknesses in VA's management of them.

SCARCE MEDICAL SPECIALIST CONTRACTING PROCESS

In 1966, the Congress authorized VA to purchase specialized medical services from external sources when VA deems it necessary. VA 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 medical specialties.

When a medical center decides that it is necessary to contract for specialist services, the medical center determines the amount of services needed and estimates the cost. Once a contract is awarded, the medical center is responsible for monitoring contractors' performance. Contracts with affiliated medical schools may be noncompetitive, negotiated contracts; contracts with other private providers must be awarded through competitive bidding.

Following the 1987 hearing, VA made some changes to improve its oversight of medical centers' contract activities. For example, VA now requires medical centers to submit all proposed contracts for headquarters review. Previously, VA headquarters officials reviewed only new contracts and allowed centers to "renew" existing contracts without headquarters review. Although medical centers awarded contracts for only 12-month periods, they often renewed them year after year.

Under VA's oversight process, medical centers submit proposed contracts to VA's Medical Sharing Office, which ensures that the appropriate reviewers are involved. These include officials for the responsible VA clinical service, such as anesthesiology or radiology, who review the proposals for the appropriateness and necessity of the type and amount of services to be purchased and the price to be paid. The proposed contracts are also reviewed by officials from the Offices of Acquisition and Materiel Management and General Counsel for technical conformance with acquisition regulations, prescribed contract formats, and VA policy.

INADEQUATE GUIDANCE PROVIDED TO REVIEWERS AND MEDICAL CENTER DIRECTORS

VA needs to provide better staffing guidelines for medical centers and reviewers to use when developing and evaluating contract proposals. VA's "Sharing Medical Resources Program Guide" provides a framework for centers to use in acquiring medical services from outside sources, but it does not address medical specialist contracts specifically. The Sharing Office is now developing a revised program guide. Reviewers told us that they currently rely primarily on their own judgment, as well as personal knowledge of individual medical centers and the medical marketplace, when evaluating contract proposals.

During the 1987 hearing, a VA official stated that VA would develop criteria that reviewers and medical centers could use to evaluate workload and staffing relationships for anesthesiology and radiology, by September 1988 and September 1989, respectively. VA decided to rely on a general staffing study being done by the Institute of Medicine. The first part of that study was published last September.[3] 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. VA officials believe that medical center officials and reviewers will continue to use considerable judgment when developing or evaluating contract proposals, because any staffing criteria that VA develops will be used only as guidelines.

INADEQUATE JUSTIFICATION FOR CONTRACT PROPOSALS

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. However, VA has

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

not specified support requirements, and few centers are providing adequate data when they submit proposed contracts for review.

VA does not require, for example, centers to provide information on their efforts to recruit physicians to perform specialty services as VA employees. VA policy states that medical specialist contracts may be used only when conventional employment practices have been unsuccessful. However, centers seldom provide recruiting information. The VA Health-Care Personnel Act of 1991 provides VA with new authority to increase the salaries of VA physicians in certain medical specialties. In light of this new flexibility, medical centers should be able to recruit more successfully than they have in the past.

In addition, few medical centers submitted supporting data on workload or their current staffing patterns for the contract proposals we reviewed. Only 18 of the 177 contracts we reviewed had documentation supporting the amount of services to be purchased. Most also lacked justification supporting the proposed price to be paid. Reviewers told us that they seek additional information, by telephone, when needed.

In 1987, the Inspector General found that VA centers had major internal control weaknesses that resulted in payment for contract services that were not received. Now, VA requires centers to have systems to monitor contractors' performance and thereby 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, when they submit contract proposals. As a result, VA reviewers have no way to judge whether the medical centers' systems can effectively monitor contract activities.

INADEQUATE FOLLOW UP OF CONTRACT MODIFICATIONS

VA needs to institute follow-up procedures to ensure that required contract modifications resulting from its review process are made. Although the Inspector General reported this as a problem during the 1987 hearing, VA has not taken steps to ensure that contract modifications are made.

Medical centers frequently did not provide evidence that they had made required changes, although VA had requested them to do so. Of the contracts we reviewed, 129 had been approved contingent on certain changes being made. But, executed contracts were not provided for 85 cases so there was no way for VA to determine whether changes had been made. For the 44 cases where executed contracts were provided, changes had not been made for 17 contracts.

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