Department of Veterans Affairs
Office of Inspector General

Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements

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VA Office of Inspector General
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Executive Summary

Introduction

The Office of Inspector (OIG) conducted this audit to evaluate the effectiveness of performance monitoring of noncompetitive clinical sharing agreements to specifically determine if Veterans Health Administration (VHA) controls over performance monitoring ensured that VA received the services it paid for.

Sharing agreements are written contracts that allow VA to buy, sell, or exchange health care resources and services with non-VA facilities. Title 38 of the United States Code (USC), Section 8153, "Sharing of Health Care Resources," authorizes VA to enter into noncompetitive sharing agreements with affiliated institutions and other entities associated with these affiliated institutions. In practice, many high cost sharing agreements are noncompetitive agreements through which VA buys clinical services from affiliated medical schools and entities associated with medical schools, such as university hospitals, clinical departments, and medical practice groups.

At the end of fiscal year (FY) 2007, Veterans Integrated Service Networks (VISNs) reported having 669 noncompetitive clinical sharing agreements valued at $575 million. Of these 669 agreements, 178 (27 percent) agreements, each valued at $100,000 or more, were for surgical and anesthesiology services provided at VA medical centers and healthcare systems (referred to as VAMCs in this report). These 178 noncompetitive agreements had a total value of about $200.6 million and included three general types of agreements—121 agreements based on full-time equivalent employees (FTE) for which VA measures performance in terms of hours or days, 55 per-procedure agreements for which VA measures performance in terms of the number and types of procedures performed, and 2 capitation-based agreements for which VA measures performance in terms of the number of patients served.

VA has two offices that provide policy direction to contracting activities. At the Department level, VA's Office of Acquisition and Logistics develops policy for VA-wide acquisition activities. It manages VA's Contracting Officer Certification Program and warrants all VA contracting officers. This office also manages other acquisition training, including continuing education for contracting staff. Within VHA, the Prosthetics and Clinical Logistics Office (PCLO) Medical Sharing Team provides "day-to-day" policy direction and technical assistance to the VISNs, where VHA's contracting activities are located, and to the VAMCs, which receive and monitor the contracted services.

VA Directive 1663, "Health Care Resources Contracting—Buying, Title 38 U.S.C. 8153," dated August 10, 2006, describes the major rules for buying health care resources and services. In addition, because sharing agreements are contracts, they must also

comply with certain provisions of the Federal Acquisition Regulation (FAR) and VA Acquisition Regulation (VAAR). FAR and VAAR require contracting officers to ensure compliance with sharing agreement terms and allow contracting officers to appoint contracting officers' technical representatives (COTRs) to monitor contractor performance and certify contractor invoices for payment.

Our audit focused on surgical and anesthesiology noncompetitive clinical sharing agreements that were in effect on September 30, 2007. The surgical agreements included all surgical specialties, such as orthopedics, ophthalmology, urology, and cardiac surgery. We selected surgical and anesthesiology agreements because they represent the largest portion—in number and dollar value—of all clinical sharing agreements. We conducted onsite work at eight randomly selected VAMCs. At each VAMC, we reviewed all surgical and anesthesiology sharing agreements valued at $100,000 or more. In all, we reviewed a total of 58 agreements, including 34 FTE-based agreements and 24 per-procedure agreements. None of the eight VAMCs used capitation-based agreements to acquire surgical or anesthesiology services. We limited our review to only those services that contractors provided onsite at VAMCs. We conducted our audit work from November 2007 through May 2008.

Results

VHA lacks reasonable assurance it received the services it paid for because performance monitoring controls over noncompetitive clinical sharing agreements are not effective. Strengthening controls over performance monitoring of noncompetitive clinical sharing agreements could save VHA about $9.5 million annually or $47.4 million over 5 years. Of the estimated savings, only about $96,000 in charges resulting from calculation errors may be recoverable because the terms of most of the sharing agreements we reviewed did not include provisions for adjusting payments. We found performance monitoring weaknesses for all 58 surgical and anesthesiology sharing agreements we reviewed at the 8 VAMCs. As a result, for 30 (52 percent) of the 58 agreements, VAMCs overpaid contractors because COTRs did not verify that VAMCs received the services required at the prices specified.

In addition to performance monitoring issues, we also found that during negotiations of per-procedure sharing agreements, VISN contracting officers agreed to pay at least full Medicare rates. However, the full Medicare rates include a practice component for overhead charges that contractors do not incur when they provide services at VAMCs. Excluding the Medicare practice component, as required by VA policy, could have saved VHA about $2.5 million annually or $12.4 million over 5 years.

Issue 1. VHA Needs To Improve Controls Over Sharing Agreement Performance Monitoring

VHA needs to strengthen controls over sharing agreement performance monitoring to ensure VAMCs receive the services they purchase. Performance monitoring for all 58 agreements at the 8 VAMCs needed improvement. As a result, for 30 sharing agreements (17 FTE-based and 13 per-procedure agreements), VAMCs overpaid contractors for services that were not provided, not needed, or incorrectly billed. For the FTE-based sharing agreements, COTRs did not monitor clinical staff levels provided, and for the per-procedure sharing agreements, COTRs did not always ensure that services were received or were needed, and they did not verify that contractors correctly calculated their Medicare-based charges.

FTE-Based Sharing Agreement Monitoring. Inadequate monitoring of sharing agreements at the eight VAMCs resulted in overpayments of about $3.5 million for clinical services that were not provided in FY 2007. For the 34 FTE-based sharing agreements, COTRs generally ensured that monthly charges by the contractors conformed with contract prices, but they did not determine the actual amount of time contract providers had worked or whether the hours worked were meeting the hours that contractors were required to provide. Of the eight VAMCs, three had no monitoring procedures in place at all; three used clinical reports to determine contractor performance, but did not have procedures to reconcile the workload in clinical reports to the time requirements in the sharing agreements; and the other two used contractor time records to monitor sharing agreements, but did not have procedures to verify the accuracy of the time records.

Per-Procedure Sharing Agreement Monitoring. Ineffective monitoring of per-procedure sharing agreements resulted in overpayments of about $682,000 for clinical services that were not provided, not needed, or incorrectly billed in FY 2007. While COTRs generally verified that contractors had performed the clinical services they billed for, two VAMCs paid about $586,000 for services not received or not needed. One VAMC paid for clinic treatments the contractor did not provide. Another VAMC paid for clinical services that the sharing agreement did not clearly require and the VAMC did not need. In addition, three VAMCs overpaid about $96,000 because contractors charged incorrect rates and the COTRs did not effectively review the charges before certifying contractor invoices.

We attributed the sharing agreement monitoring deficiencies at the eight VAMCs to three factors: (1) sharing agreements did not specifically and accurately state performance requirements, (2) VISN officials did not adequately oversee COTR activities, and (3) COTRs did not have sufficient training to monitor clinical service sharing agreements.

Sharing Agreements Did Not Specifically and Accurately State Performance Requirements. COTRs were unable to adequately monitor performance because the

performance requirements were not clearly specified in the sharing agreements. Contractor performance requirements should be detailed enough for COTRs, as well as contracting officers and contractors, to know at a minimum what types of services will be provided, who will provide the services, and the rates to be charged. In addition to the vague performance requirements, inaccurate performance requirements for FTE-based sharing agreements also negatively impacted the COTRs' abilities to effectively monitor these agreements. Sharing agreement requirements that accurately reflect the service needs of the VAMC are especially important when agreements have no provisions allowing COTRs to adjust contractor payments based on the actual work performed.

VISN Officials Did Not Adequately Oversee COTR Activities. As part of their contract administration responsibilities, FAR and VAAR require contracting officers to ensure that contractors comply with the terms of agreements. Contracting officers may do this by delegating COTRs at the VAMCs to monitor contractor performance and certify invoices for payment. Ideally, sharing agreement performance monitoring should be a team effort between the contracting officer, the COTR, and VISN and VAMC management. For 57 of the 58 contracts we reviewed, VISN contracting officers had appointed COTRs. However, the contracting officers did not provide the COTRs clear guidance about their responsibilities, nor did they implement procedures to routinely review the COTRs' monitoring activities to ensure they were effective. Furthermore, management officials at the VISNs did not establish any procedures to evaluate the effectiveness of sharing agreement performance monitoring activities.

COTRs Did Not Have Sufficient Training To Monitor Clinical Sharing Agreements. COTRs at all eight VAMCs needed additional guidance and training on how to establish effective monitoring systems for FTE-based and per-procedure clinical service sharing agreements. Most of the COTRs had completed training on contract monitoring, but this training provided only general contract monitoring guidance and did not address clinical service sharing agreement monitoring in particular. COTRs were especially concerned about their lack of knowledge of Medicare-based charges commonly used in the per-procedure sharing agreements. None of the COTRs had received training on understanding and using Medicare rates. Without this knowledge and understanding, the COTRs' abilities to detect billing errors, such as using the wrong rate for a particular procedure, are diminished.

Issue 2. VHA Needs To Ensure Contracting Officers Receive Training on Medicare Rates

The terms and conditions in 21 of the 24 per-procedure sharing agreements stated that the contractors would charge VAMCs 100 percent or more of Medicare Part B rates for each procedure performed. This means that under the terms of the sharing agreements, the VAMCs are required to pay for all three components of the procedures—work, malpractice, and practice. However, when VISN contracting officers negotiated the sharing agreements, it was not appropriate to agree to the full Medicare rates because

these rates include the practice component, which factors in costs for maintaining a practice, such as renting office space, buying supplies and equipment, and paying for other facility-related costs. The practice component is not applicable for services provided at VAMCs since the VAMCs, not the contractor, incur all facility-related costs included in this component.

VA Directive 1663 explicitly requires VAMCs to exclude the practice component from reimbursements. Ensuring that VISN contracting officers negotiate per-procedure sharing agreement rates that exclude the Medicare Part B practice component could save VHA about $2.5 million annually or $12.4 million over 5 years.

Conclusion

Strengthening performance monitoring controls over noncompetitive clinical sharing agreements could save VHA about $9.5 million annually or $47.4 million over 5 years. In FY 2007, insufficient monitoring of surgical and anesthesiology sharing agreements resulted in VAMCs overpaying $4.1 million for services that were not received, not needed, or incorrectly billed. For the 34 FTE-based sharing agreements, most COTRs did not monitor clinical staff levels provided, and for 21 of the 24 per-procedure sharing agreements, COTRs did not verify that contractors correctly calculated Medicare-based charges prior to certifying contactor invoices for payment. Furthermore, strengthening procedures for negotiating per-procedure sharing agreements to ensure VAMCs are only required to pay for the Medicare Part B work and malpractice components—and not the practice component—could save VA about $2.5 million annually or $12.4 million over 5 years.

Recommendations

1. We recommended that the Under Secretary for Health ensure that VISNs establish standardized written procedures for monitoring FTE-based and per-procedure clinical service sharing agreements.

2. We recommended that the Under Secretary for Health establish VISN-level oversight controls to ensure that COTRs are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.

3. We recommended that the Under Secretary for Health implement procedures to ensure that COTRs verify that Medicare-based sharing agreement charges are accurately calculated prior to certifying contractor invoices.

4. We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.

5. We recommended that the Under Secretary for Health instruct the VISN contracting officers to initiate recovery of overpayments identified by our audit, as appropriate.

6. We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.

7. We recommended that the Under Secretary for Health implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendations of the report and provided acceptable implementation plans. The Under Secretary also agreed with the monetary benefits of $59.8 million. (See Appendix C, pages 21–24, for the full text of the Under Secretary's comments.) In response to the audit recommendations, the Under Secretary agreed to establish standard procedures, VISN level oversight controls, and COTR training for sharing agreement monitoring. He also agreed to implement procedures that ensure the accuracy of Medicare-based charges is verified, to require VISN contracting officers to begin immediate recovery of the overpayments we identified, and to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component from contract rates. We will follow up on the implementation of the planned improvement actions.

(original signed by:)
BELINDA J. FINN
Assistant Inspector General
for Auditing

Introduction

Purpose

The purpose of the audit was to evaluate the effectiveness of performance monitoring of noncompetitive clinical sharing agreements to specifically determine if VHA controls over performance monitoring ensured that VA received the services it paid for.

Background

Sharing Agreement Authority. Sharing agreements are written contracts that allow VA to buy, sell, or exchange health care resources and services with non-VA facilities. Title 38, USC, Section 8153, "Sharing of Health Care Resources," authorizes VA to enter into noncompetitive sharing agreements with affiliated institutions and other entities associated with these affiliated institutions. In practice, many high cost sharing agreements are noncompetitive agreements through which VA buys clinical services from affiliated medical schools and entities associated with medical schools, such as university hospitals, clinical departments, and medical practice groups.

Number, Value, and Types of Sharing Agreements. At the end of FY 2007, VISNs reported having 1,714 clinical service sharing agreements valued at about $1.7 billion. Noncompetitive agreements accounted for 669 (39 percent) of the 1,714 agreements and had a total value of $575 million. Of these 669 noncompetitive agreements, 178 (27 percent) agreements, each valued at $100,000 or more, were for surgical and anesthesiology services provided at VAMCs. These 178 noncompetitive agreements had a total value of about $200.6 million and included three general types of agreements:

- FTE-Based Agreements. For these agreements, VA measures performance in terms of hours or other periods of time. Performance requirements for FTE-based sharing agreements are generally based on a specified number of hours of work at a specified rate. For example, a sharing agreement may call for 0.5 FTE orthopedic surgeons, which is equivalent to about 20 hours per week. Reimbursements should be based on the contractor meeting the time requirements specified. Of the 178 surgical and anesthesiology agreements, 121 were FTE-based.

- Per-Procedure Agreements. For these agreements, VA measures performance in terms of the number and types of procedures completed. For per-procedure sharing agreements, the amount of work to be performed is variable, but the price for each type of clinical procedure completed is stated in the contract. All medical procedures are assigned a code, called a Current Procedural Terminology (CPT) code. Sharing agreements should identify the specific CPT codes and the estimated quantity that will be performed. Reimbursements are based on the numbers and types of procedures the contractor performs. Of the 178 surgical and anesthesiology agreements, 55 were per-procedure.

- Capitation-Based Agreements. For these agreements, VA measures performance in terms of the number of patients served. Sharing agreements should specify a cost per patient. Reimbursement is based on the number of patients the contractor treats. Of the 178 surgical and anesthesiology agreements, 2 were capitation-based.

VA and VHA Program Office Responsibilities. VA has two offices that provide policy direction to contracting activities. At the Department level, VA's Office of Acquisition and Logistics develops policy for VA-wide acquisition activities. It manages VA's Contracting Officer Certification Program and warrants all VA contracting officers. This office also manages other acquisition training, including continuing education for procurement staff. Within VHA, the PCLO Medical Sharing Team provides "day-to-day" policy direction and technical assistance to VISNs and VAMCs with sharing agreements.

In recent years, VHA has consolidated contracting activities at the VISNs. Under this structure, contracting officers are no longer employees of the VAMCs; instead, they are VISN employees. Some VISNs have centralized contracting activities at one location, while others have located contracting officers at the VAMCs they support, but the contracting officers are employed and supervised by the VISN. COTRs, who are appointed by contracting officers to monitor contractor performance, are typically VAMC employees. In most cases, they are the administrative officers of the VAMC clinical activities requiring the contracted services and monitor sharing agreement performance in addition to their primary duties.

Sharing Agreement Policies and Procedures. VA Directive 1663, "Health Care Resources Contracting—Buying, Title 38 U.S.C. 8153," dated August 10, 2006, describes the major rules for buying health care resources and services. In addition, because sharing agreements are contracts, they must also comply with certain provisions of the FAR and VAAR.

Performance Monitoring Responsibilities. FAR and VAAR require contracting officers to ensure compliance with the terms of contracts (including sharing agreements). They may designate COTRs to furnish technical advice or supervise the work performed under the contract. When a contracting officer delegates certain contract administration functions to the COTR, the legal responsibility for the contract remains with the contracting officer. The COTR functions as the "eyes and ears" of the contracting officer by monitoring technical performance, verifying and certifying contractor invoices, and reporting any potential or actual problems to the contracting officer.

Performance Monitoring Controls. VA Directive 1663 requires contracting officers to ensure that effective controls are in place to monitor contractor performance. The VAMC or VISN must have a system in place for monitoring what work is being performed, which contract providers are performing the work, and a method for verifying that contractor charges are correct for work performed. Before certifying payments, the

COTR must verify by reviewing the appropriate documentation that VA has received the services called for under the sharing agreements. Whenever significant changes take place in the sharing agreement requirements or in the contractor's ability to meet the existing performance requirements, the COTR is responsible for reporting these conditions to the contracting officer, so that modifications or other appropriate actions can be undertaken.

Prior OIG Reviews. In 2005, the OIG issued the *Evaluation of VHA Sole-Source Contracts with Medical Schools and Other Affiliated Institutions* (05-01318-85, February 16, 2005), which addressed numerous issues related to general contracting practices, contract pricing, and conflicts of interest and other legal issues. The evaluation concluded that acquisition planning and justifications for contracting out for services were inadequate, VA was overpaying affiliates for services, VA employees were violating conflict of interest laws, and solicitations for services were outside the scope of the sharing agreement authority.

Scope and Methodology

To address the audit objective, we identified applicable Federal regulations and VA and VHA policies and procedures related to sharing agreement administration and monitoring. We also interviewed responsible VA, VHA, and PCLO program officials about sharing agreement oversight processes and controls. We conducted our audit work from November 2007 through May 2008.

We focused on surgical and anesthesiology noncompetitive clinical sharing agreements that were in effect on September 30, 2007. The surgical agreements included all surgical specialties, such as orthopedics, ophthalmology, urology, and cardiac surgery. We selected surgical and anesthesiology agreements because they represent the largest portion—in number and dollar value—of all clinical sharing agreements. We conducted onsite work at eight randomly selected VAMCs. At each VAMC, we reviewed all surgical and anesthesiology sharing agreements valued at $100,000 or more. In all, we reviewed a total of 58 agreements. We limited our review to only those services that were provided onsite at VAMCs.

We selected eight VAMCs using a probability proportional to size statistical sampling approach. The measure of size we used was the number of surgical and anesthesiology sharing agreements that were in effect on September 30, 2007 at each VAMC site. This methodology ensured that VAMCs with more contracts would have a higher probability of being selected into the sample while still allowing all VAMCs to have a known, non-zero probability of selection. We then reviewed all 58 surgical and anesthesiology sharing agreements that were in effect on September 30, 2007 at the eight VAMCs. The total annual cost of these 58 agreements was $30.0 million. Table 1 shows the VAMCs we visited and the number and types of agreements we reviewed at each site.

Table 1. VAMCs and Agreements Reviewed

VAMC	Location	Sharing Agreements Reviewed		
		FTE-Based	Per-Procedure	Total
Miami VA Healthcare System	Miami, FL	6	3	**9**
Minneapolis VA Medical Center	Minneapolis, MN	11	3	**14**
Richard L. Roudebush VA Medical Center	Indianapolis, IN	6	0	**6**
South Texas Veterans Health Care System	San Antonio, TX	3	2	**5**
VA Long Beach Healthcare System	Long Beach, CA	2	0	**2**
VA Nebraska Western Iowa Health Care System	Omaha, NE	1	13	**14**
VA Puget Sound Health Care System	Seattle, WA	4	2	**6**
VA Sierra Nevada Health Care System	Reno, NV	1	1	**2**
	Total Agreements	34	24	**58**

For each sharing agreement in our sample, we evaluated how the agreement was monitored, whether the statement of work was clear and adequately supported, and whether VA received the services paid for at the rates provided in the sharing agreement terms. We interviewed the contracting officers and COTRs, as well as other clinical and administrative staff who were involved in requesting, justifying, or preparing the agreements. We reviewed workload reports, including operating room (OR) logs, anesthesiology logs, and clinic schedules; work schedules and time and attendance records; patient treatment records; and other documents used to monitor contractor performance. We also interviewed selected clinicians who worked at the VAMCs under the terms of the agreements.

To identify all clinical sharing agreements, we obtained a database of clinical services agreements from the PCLO. However, when we attempted to verify the number of agreements in the PCLO database for one VISN, we found that the database was missing many agreements. Therefore, we developed our own database by contacting each VISN directly and requesting a list of all active clinical service agreements. Once we received the lists, we reviewed them for completeness, and we made follow-up telephone calls and sent follow-up emails to VISN officials on missing data elements until we were satisfied we could properly identify most agreements that fell within our scope. We were unable to verify with certainty that our database identified all possible agreements administered by VAMCs nationwide. Therefore, we may have underestimated our projected cost savings. We relied on the database we developed to identify the universe of 178 noncompetitive surgical and anesthesiology sharing agreements.

During the audit, we relied on computer-processed data to determine clinical workload for the sharing agreements we reviewed. We assessed the reliability of workload information obtained from Veterans Information System and Technology Architecture (VistA) by comparing it with work schedules and interviews with clinical staff. Based on these tests and assessments, we concluded the data were sufficiently reliable to meet the audit objective.

Our assessment of internal controls focused on those controls relating to our audit objective. We conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Results and Conclusions

Issue 1. VHA Needs To Improve Controls Over Sharing Agreement Performance Monitoring

Finding

VHA lacks reasonable assurance it received the services it paid for because performance monitoring controls over noncompetitive clinical sharing agreements are not effective. Strengthening controls over performance monitoring could save VHA about $9.5 million annually or $47.4 million over 5 years. Of the estimated savings, only about $96,000 in charges resulting from calculation errors may be recoverable, because the terms of most of the sharing agreements we reviewed did not include provisions for adjusting payments.

FAR and VAAR require contracting officers to ensure compliance with sharing agreement terms and allow them to appoint COTRs to monitor contractor performance and certify contractor invoices for payment. Our review of 58 surgical and anesthesiology sharing agreements at 8 VAMCs found that controls over contract performance monitoring for all 58 agreements needed strengthening. As a result, for 30 (52 percent) of the 58 agreements, VAMCs overpaid contractors because COTRs did not verify that VAMCs received the services required at the prices specified. For the 34 FTE-based sharing agreements, COTRs did not monitor clinical staff levels provided. For the 24 per-procedure agreements, COTRs did not always ensure that all services charged were received or were needed, and COTRs did not verify that contractors correctly calculated Medicare-based charges.

FTE-Based Sharing Agreement Monitoring. Inadequate monitoring of sharing agreements at the eight VAMCs resulted in overpayments of about $3.5 million for clinical services that were not provided or not needed during FY 2007. Performance requirements for FTE-based sharing agreements are generally based on contract providers working a specified number of hours at specified rates. Most of the FTE-based sharing agreements we reviewed required contractors to provide a certain level of FTE, where 1.0 FTE generally equated to a minimum of 40 hours of work per week, or 2,080 hours per year. The amount of time specified in these FTE-based sharing agreements is fixed for the periods the sharing agreements are in effect, except when provisions authorizing adjustments of work requirements are included in the agreements, or unless the sharing agreements are modified to change the FTE levels.

For the 34 FTE-based sharing agreements at the 8 VAMCs, most COTRs ensured that the rates billed by the contractors on monthly invoices conformed to contract prices, but they did not determine the amount of time contract providers had actually worked or whether the hours worked met the FTE levels that contractors needed to provide. Of the eight VAMCs, three had no monitoring procedures, three used clinical reports to determine

contractor performance, and the other two used contract providers' time records to monitor sharing agreements, as described on the next page.

No Monitoring Performed. COTRs at VAMCs Seattle, Omaha, and Reno did not have procedures for monitoring contract providers' work times for their six FTE-based sharing agreements. COTRs did not identify shortages in the hours worked in FY 2007 for three agreements because they did not compare the time worked by contract providers to the sharing agreement requirements. The following example illustrates the impact of not having monitoring procedures.

> **Anesthesiology at VAMC Seattle.** This sharing agreement required the affiliate to provide 2.7 FTE in anesthesiology services. An administrative officer who acted as the COTR, but was not officially delegated this authority, certified all contractor invoices for payment without verifying the hours worked. As a result, the administrative officer did not identify that the actual time provided by the contract anesthesiologists only equated to about 2.4 FTE. The contractor charges that exceeded the actual time worked during FY 2007 were $106,843.

Monitoring Clinical Work. At VAMCs Miami, San Antonio, and Indianapolis, COTRs stated that while they periodically reviewed clinical performance to determine if contract providers were providing the required services, they did not monitor the contract providers' time for their 15 FTE-based sharing agreements. Periodic reviews of clinical performance measures, such as the number of surgeries performed and the number of clinic visits, do not measure FTE-based performance. Instead, the COTRs should have implemented procedures to systematically determine the actual time that contract providers spent at VA in surgery, in clinics, and providing other services, as required under the terms and conditions of the sharing agreement. Because they did not monitor the time worked by contract providers, the COTRs did not identify significant shortfalls in the actual hours providers worked in FY 2007 for 9 of the 15 FTE-based agreements, as illustrated in the following example.

> **Peripheral Vascular Surgery at VAMC Indianapolis.** This sharing agreement required the contractor to provide 2.0 FTE peripheral vascular surgeons for clinical services during FY 2007. Our review determined that the time worked during the year only accounted for about 1.14 of the 2.0 FTE, resulting in an overpayment of $333,030. The COTR stated that she reviewed the various clinical workload reports, such as the OR log and clinic appointments, and believed the contract surgeons were meeting their requirements, but she did not monitor their time.

Monitoring Contractor Time Records. COTRs monitored contract providers' time records, such as sign-in/sign-out sheets, but did not ensure they were complete and accurate for the 13 FTE-based sharing agreements at VAMCs Minneapolis and Long

Beach. At VAMCs Minneapolis and Long Beach, the terms of the FTE-based sharing agreements allowed the VAMCs to adjust payments according to the hours the contract providers actually worked. The COTRs generally reviewed the providers' time records that were maintained at the VAMC before certifying contractor invoices for payment and based the amounts they certified on the time the providers had documented. However, the COTRs generally did not have procedures for ensuring that the contract providers' entries were accurate. The following example illustrates this problem.

> **Ophthalmology Services at VAMC Minneapolis.** For this 1.0 FTE sharing agreement, the COTR used timesheets she obtained from the contract provider each month to determine the amount to be paid to the contractor. Believing that the provider was working more than 40 hours per week, the COTR authorized the provider's supervisor to allow 20 additional days of leave that exceeded the terms of the agreement. However, the COTR never tested the accuracy of the provider's timesheets. Our review of the provider's timesheets and the work he performed showed that the timesheets were not always accurate and that the hours he worked were not exceeding his FTE requirements. The cost to the VAMC for the additional leave was $24,000.

Per-Procedure Sharing Agreement Monitoring. Ineffective monitoring of per-procedure sharing agreements resulted in overpayments of about $682,000 for clinical services that were not provided, not needed, or incorrectly billed in FY 2007. Performance requirements for per-procedure sharing agreements are based on the number and types of procedures contract providers complete.

For most of the per-procedure sharing agreements we reviewed, contractors calculated their charges using the same method the Medicare program uses to reimburse physicians for outpatient services (commonly referred to as Medicare Part B). Under this method, all medical procedures are assigned a standard code, called a CPT code. Each procedure designated by a CPT code is comprised of three components or relative value units (RVUs)—work, malpractice, and practice. The work component reflects the time and intensity of a procedure in relation to other procedures. The practice component reflects the costs associated with maintaining a practice, such as renting office space, buying supplies and equipment, and maintaining staff and is appropriate for services provided at contractor locations. The malpractice component represents costs related to maintaining malpractice insurance.

To calculate a charge for a CPT code based on Medicare Part B rates, the contractor multiplies each component by a geographic index to adjust for regional differences in the costs for each component. The work component is also multiplied by a budget neutrality factor before applying the work geographic index. The total values for each geographic adjusted component are added together to arrive at a total RVU. This total RVU is multiplied by a dollar conversion factor to arrive at the total charge for the procedure.

Ineffective monitoring practices by the COTRs resulted in two VAMCs overpaying contractors for services that were not provided or not needed and three VAMCs paying for incorrectly calculated Medicare-based charges. In addition, one VAMC paid for charges that exceeded an agreement's daily per-procedure cap. Each type of payment error is explained below

Monitoring Per-Procedure Services. While COTRs generally verified that contract providers performed the clinical services charged, the monitoring procedures for one sharing agreement did not prevent payments for clinical services that were not needed. For VAMC San Antonio's urology sharing agreement, the contractor provided oversight of VA staff physician assistants (PAs) that was not required under the terms of the agreement or necessary under VA standards for PA supervision. The cost of the unnecessary oversight in FY 2007 was $557,954. (See pages 10–11 for more detail on this sharing agreement.)

For VAMC Miami's hand surgery sharing agreement, the COTR did not ensure that all services charged had been provided before certifying invoices for payment. This agreement required contract surgeons to perform surgeries at Medicare-based per-procedure rates and to treat patients at VAMC clinics at negotiated fixed rates.

> **Hand Surgery at VAMC Miami.** For clinic services, this sharing agreement established a fixed price of $11,232 per month for 100–120 clinic visits, but did not specify a rate for fewer than 100 clinic visits per month. During FY 2007, the actual number of clinic visits reached 100 per month only twice during the year and averaged 79 per month. Although the COTR monitored the number of clinic visits, she did not notify the contracting officer that the clinic work was not meeting the number of clinic visits provided for in the sharing agreement or determine what the appropriate rate of payment should be. The cost of clinic visits that fell below 100 visits per month during the year was $28,192.

Monitoring Medicare Rate Calculations. For 11 per-procedure sharing agreements at VAMCs Omaha, Minneapolis, and Reno, contractors charged the wrong Medicare rates. Overcharges due to errors in calculating Medicare rates totaled $88,627. None of the VAMCs had developed effective procedures for verifying the accuracy of Medicare-based per-procedure charges. The following two examples illustrate this problem.

> **Neurosurgery at VAMC Reno.** The contractor overcharged $12,614 for services provided during FY 2007 because it used the wrong Medicare rates for numerous CPT codes. During the year the contractor billed the VAMC for 83 procedures with the CPT code 95999, "neurological procedure" at a rate of $135 each, for a total of $11,537. However, Medicare listed that CPT code as a no-charge item. The COTR certified the charges without verifying the rates.

General Surgery at VAMC Omaha. During FY 2007, the contractor charged the VAMC for 31 clinical procedures based on CPT codes reimbursed at the Medicare rate. For all 31 procedures the contractor charged, the Medicare rates used by the contractor differed from the rates applicable for Omaha posted at the Medicare website. The total difference was $1,022. The contractor confirmed the overcharge and attributed the errors to a new commercial software tool that had recently been implemented. The COTR did not review the charges prior to certifying them for payment because he had insufficient knowledge of Medicare rate computation.

Monitoring Procedure Charges with Daily Caps. One VAMC Minneapolis sharing agreement established limits on the amount of per-procedure work that could be charged each day. However, the COTR's monitoring procedures did not prevent overpayments for charges exceeding the daily cap.

Ophthalmology at VAMC Minneapolis. This per-procedure sharing agreement had a daily cap of $1,700 for procedures performed in ophthalmology clinics. Because the COTR did not consistently review the invoices by the day, she did not determine that the contractor had exceeded the daily clinic cap on three invoices, for a total overpayment of $7,040.

Reasons for Sharing Agreement Monitoring Weaknesses

We attributed the sharing agreement monitoring deficiencies, discussed in the previous sections, at the eight VAMCs to three factors: (1) sharing agreements did not specifically and accurately state performance requirements, (2) VISN officials did not adequately oversee COTR activities, and (3) COTRs did not have sufficient training to monitor clinical sharing agreements.

Sharing Agreements Did Not Specifically and Accurately State Performance Requirements. For COTRs to effectively monitor contractor performance, the sharing agreement should contain specific and accurate performance measurements, and the COTRs must fully understand and implement these requirements. Contractor performance requirements should be detailed enough for the COTR, as well as the contracting officer and contractors, to know at a minimum what types of services will be provided, who will provide the services, how performance will be measured (for example, by days, hours, or number of procedures), and the rates to be charged. The following example illustrates how sharing agreement monitoring was impaired by vague performance requirements.

Urology at VAMC San Antonio. This sharing agreement required contract urologists to "provide appropriate level of guidance" to VA PAs who ran daily urology clinics. About 90 percent of the contract urologists'

work with the PAs consisted of reading and approving patient notes, rather than providing direct patient care. However, the sharing agreement did not specify either the number of PA notes the contract urologists should review or the rate of payment applicable to that service. The Chief of Urology, who was a contract provider, determined that the contract urologists should review all PA notes, even though this was neither a VA requirement nor a customary practice. Using a random sample of clinic visits, we determined that the VAMC overpaid the contractor approximately $557,954 during FY 2007 for these services.[1]

The overpayments for Medicare-based charges discussed on page 9 also illustrate the need for the sharing agreements to clearly show the applicable rates that will be charged for per-procedure agreements. Clearly showing these rates would enable individuals without Medicare billing experience to compute and verify the rates charged for each procedure. A schedule of the rates to be paid for each CPT code could help improve sharing agreement monitoring and prevent payment errors.

In addition to the sharing agreements with vague performance requirements, inaccurate performance requirements for FTE-based sharing agreements also contributed to the monitoring weaknesses. Sharing agreement requirements that accurately reflect the service needs of the VAMC are especially important when agreements have no provisions allowing COTRs to adjust contractor payments based on the actual work performed. The following example illustrates how inaccurate performance requirements affected monitoring.

Cardiothoracic (CT) Surgery at VAMC Miami. This sharing agreement required the University of Miami to provide 1.5 FTE CT surgeons during the period December 1, 2005 through November 30, 2007. During FY 2007, the university provided a 1.0 FTE CT surgeon to the VAMC but not the remaining 0.5 FTE. Neither the COTR nor the contracting officer could explain why the 0.5 FTE was needed in the first place, and no workload analysis justifying the 1.5 FTE was identified. Furthermore, the number of CT surgeries performed during FY 2007 was much lower than expected and only accounted for about 0.6 FTE contract surgeon's time. However, the COTR certified payments to pay the university the full annual agreement amount, which included $521,037 for services the VAMC did not receive in FY 2007.

VISN Officials Did Not Adequately Oversee COTR Activities. As part of their contract administration responsibilities, FAR and VAAR require contracting officers to

[1]To estimate the total amount the VAMC should have paid for the allowable procedures, we identified all of the procedures performed by VAMC physician assistants and randomly selected 100 of those procedures for review. For each sample clinic note, we determined if the physician had the required patient contact. We used the cost of each sample procedure to project the sample results to the universe.

ensure that contractors comply with the terms of agreements. They may do this by delegating COTRs at the VAMCs to monitor contractor performance and certify invoices for payment. Ideally, sharing agreement performance monitoring should be a team effort between the contracting officer, the COTR, and VISN and VAMC management. For 57 of the 58 contracts we reviewed, VISN contracting officers had appointed COTRs. However, the contracting officers did not provide the COTRs clear guidance about their responsibilities, nor did they implement procedures to routinely review the COTRs' monitoring activities to ensure they were effective. Furthermore, management officials at the VISNs and VAMCs did not establish any procedures to evaluate the effectiveness of sharing agreement performance monitoring activities.

Clear Guidance Not Provided. To effectively monitor contractor performance, COTRs must fully understand their responsibilities, as well as the terms and conditions of the sharing agreement. For seven of the eight VAMCs, VISN contracting officers did not provide COTRs specific guidance or instructions on how to effectively monitor contractor performance. Therefore, each COTR determined what monitoring procedures to use. For example, VAMC Miami's COTR appointment letters required, "Monitoring the contractor's performance of the technical requirements of the contract to assure that performance is strictly within the scope of the contract." However, the letters did not provide specific guidance as to what procedures or information the COTRs should use to monitor "the contractor's performance of the technical requirements."

VAMC Minneapolis was the exception—the COTR appointment letters at this VAMC did provide COTRs specific monitoring instructions. The appointment letters required COTRs to monitor contract provider time and attendance logs, to periodically review actual performance versus scheduled performance, to inform the contracting officer of any adverse conditions noted or of any failure of the contractor to comply with any of the terms of the contract, and to verify the number and types of providers charged to the contract. In our opinion, while these detailed letters did not entirely prevent monitoring problems at VAMC Minneapolis, they did contribute to generally stronger monitoring procedures than what we found at other VAMCs.

Regular Monitoring Did Not Occur. VISN contracting officers at all eight VAMCs did not oversee the monitoring activities of the COTRs, and VISN officials had not established any procedures to evaluate the effectiveness of performance monitoring activities. In our opinion, to strengthen monitoring of clinical service sharing agreements, VISNs should establish COTR monitoring procedures and documentation requirements. VISNs should also implement a review program in which VISN staff determine the procedures COTRs are using; whether the procedures meet VISN requirements; and whether they ensure that sharing agreement requirements are accurate, that VA is receiving the specified services, and that contractors are charging rates provided in the agreements.

COTRs Did Not Have Sufficient Training To Monitor Clinical Sharing Agreements. COTRs at all eight VAMCs needed additional guidance and training on how to establish effective monitoring procedures for FTE-based and per-procedure clinical services sharing agreements and how to ensure VAMCs received all the agreed upon services before certifying contractor invoices. Most of the COTRs had completed training on contract monitoring, but this training provided only general contract monitoring guidance and did not address clinical service sharing agreement monitoring in particular.

Of particular concern to the COTRs was their lack of knowledge of Medicare-based charges, which are commonly used in the per-procedure sharing agreements. None of the COTRs had received training on understanding and using Medicare rates. They were unfamiliar with the components that make up Medicare Part B rates and how the Medicare-based charges are determined. Without this knowledge, COTRs do not have the information they need to effectively identify incorrect Medicare charges, especially when combined with poorly specified sharing agreement requirements.

Issue 2. VHA Needs To Ensure Contracting Officers Receive Training on Medicare Rates

The terms of 21 of the 24 per-procedure sharing agreements stated that the contractors would charge VAMCs 100 percent or more of Medicare Part B rates for each procedure performed. This means that under the terms of the sharing agreements, the VAMCs were required to pay for all three components of the procedures—work, malpractice, and practice. However, full Medicare rates were not appropriate, since they include a practice component. The Medicare practice component is not applicable for services provided at VAMCs, since the VAMCs, not the contractor, incur all facility-related costs included in this component. Furthermore, VA Directive 1663 explicitly requires VAMCs to exclude the practice component from reimbursements, as described in the following excerpt.

> "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."

This policy reinforces an earlier requirement in the now rescinded VHA Directive 96-039, "Scarce Medical Specialist and/or Specialized Medical Resource Sharing Agreements with Affiliates," dated May 30, 1996. That directive instructed contracting officers not to use the Medicare practice component for sharing agreement pricing for professional services performed at VAMCs, as shown in the following excerpt.

> "… if only professional services are being purchased by VA to be performed at a VA facility, reimbursement rates should be benchmarked

> against the Medicare rate less the portion attributable to office support staff or similar overhead."

Most contracting officers we interviewed were unfamiliar with Medicare Part B components and Medicare rate calculations. As a result, when they negotiated the sharing agreements, they were generally not aware that the agreed upon rates included charges for facility-related costs the contractor did not incur. In FY 2007, VAMCs paid about $1.4 million for per-procedure charges that included the Medicare practice component for the 21 sharing agreements. Ensuring that VISN contracting officers negotiate per-procedure sharing agreement rates that exclude the Medicare Part B practice component could save VHA about $2.5 million annually or $12.4 million over 5 years.

Conclusion

Strengthening performance monitoring controls over noncompetitive clinical sharing agreements could save VHA about $9.5 million annually or $47.4 million over 5 years. In FY 2007, insufficient monitoring of surgical and anesthesiology sharing agreements resulted in VAMCs overpaying $4.1 million for services that were not received, not needed, or incorrectly billed. For the 34 FTE-based sharing agreements, most COTRs did not monitor clinical staff levels provided. For the 24 per-procedure agreements, COTRs did not always ensure that all services charged were received or were needed, and COTRs did not verify that contractors correctly calculated Medicare-based charges. Furthermore, strengthening procedures for negotiating per-procedure sharing agreements to ensure VAMCs are only required to pay for the Medicare Part B work and malpractice components—and not the practice component—could save VA about $2.5 million annually or $12.4 million over 5 years. Because the terms of most of the sharing agreements we reviewed did not include provisions for adjusting payments, recovery of FY 2007 overpayments from contractors may be limited to incorrectly calculated per-procedure charges of about $96,000.

Recommendations

1. We recommended that the Under Secretary for Health ensure that VISNs establish standardized written procedures for monitoring FTE-based and per-procedure clinical service sharing agreements.

2. We recommended that the Under Secretary for Health establish VISN-level oversight controls to ensure that COTRs are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.

3. We recommended that the Under Secretary for Health implement procedures to ensure that COTRs verify that Medicare-based sharing agreement charges are accurately calculated prior to certifying contractor invoices.

4. We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.

5. We recommended that the Under Secretary for Health instruct the VISN contracting officers to initiate recovery of overpayments identified by our audit, as appropriate.

6. We recommended that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.

7. We recommended that the Under Secretary for Health implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.

Under Secretary for Health Comments

The Under Secretary for Health agreed with the findings and recommendations of the report and provided acceptable implementation plans. The Under Secretary also agreed with the monetary benefits of $59.8 million. (See Appendix C, pages 21–24, for the full text of the Under Secretary's comments.) In response to the audit recommendations, the Under Secretary agreed to establish standard procedures, VISN level oversight controls, and COTR training for sharing agreement monitoring. He also agreed to develop procedures that ensure the accuracy of Medicare-based charges is verified, to require VISN contracting officers to begin immediate recovery of the overpayments we identified, and to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component from contract rates. We will follow up on the implementation of the planned improvement actions.

Appendix A

Cost Estimate Methodologies

This appendix explains how we calculated our cost savings estimates that VHA could achieve by improving controls over performance monitoring of noncompetitive sharing agreements and providing training to contracting officers on Medicare rates to strengthen negotiations for per-procedure sharing agreements.

Estimated Savings Related to Performance Monitoring

Calculation of Overpayments for the Sampled Sharing Agreements. Because of the different requirements and monitoring procedures needed for the two types of agreements, we used different methodologies to estimate overpayments.

FTE-Based Agreements. For the FTE-based agreements, we verified the time worked by contract providers during FY 2007 and compared it to the time charged on contractor invoices. To verify the time worked by contract providers, we used the following approach:

- First, we reviewed any contract time records, such as sign-in/sign-out sheets, for the period to determine if they were reliable enough to be used to determine the time contract providers actually worked.

- We also analyzed appropriate workload data, including OR logs, patient encounter data, and clinic appointments, and, in consultation with clinical staff at the VAMCs, we estimated the time required to perform this workload. For example, to estimate providers' time in the OR, we used the actual in and out times for each procedure and added an allowance for pre-and post-operation time. To estimate clinic time, we subtracted the start time of the first appointment from the end time of the last appointment and added additional time for post-clinic activities.

- Through interviews and review of other available documentation, we then determined the time contract providers spent performing consults, rounds, research, and administrative activities. We included administrative, research, leave, conferences, holidays, and any other allowable activities in the sharing agreement. We then compared the total time worked based on this methodology to the total time paid.

Per-Procedure Agreements. For per-procedure contracts we verified that the invoiced procedures had been performed by comparing contractor charges with appropriate VAMC OR, clinic, and patient encounter records. We also determined whether the rates charged were correct by comparing the amount charged for each CPT code on contractor invoices for FY 2007 with the rate provided in the contract. Sharing agreements basing charges on Medicare rates typically referred to the Centers for Medicare and Medicaid Services (CMS) website to determine the applicable charges. We therefore calculated the

Medicare rates applicable to CPT codes billed using the formula and values from the CMS website.

Estimate of Annual VHA-Wide Potential Savings. Our sample consisted of 58 sharing agreements with a total FY 2007 cost of $30 million. We combined the results of our review of FTE-based and per-procedure agreements discussed above to arrive at a single total cost savings/better use of funds amount valued at $4.1 million.

Our estimation of cost savings and better use of funds for the population of 178 sharing agreements is based on the above results. For each sharing agreement in the population, we verified the total FY 2007 cost. The total FY 2007 actual cost for all 178 sharing agreements in our population was $95.3 million. To estimate the potential cost savings for all surgical and anesthesiology agreements nationwide, we applied cluster sampling estimation procedures to project the cost savings of $4.1 million for all 58 contracts to the universe. We estimated potential cost savings of $9.5 million per year for improved monitoring of sharing agreements. Ninety percent of all possible samples would give us a projection within the range of between $3.2 million and $15.8 million. The sample weights were post-stratified so that the sample estimate of the total 2007 charges summed to equal the known population total of $95,295,447.47. The post-stratification improved the precision of the sample estimates by reducing the variance of the sample based on the known value for the population.

Table 2 on the following page shows the estimated overpayments resulting from inadequate monitoring of 30 sharing agreements. The table shows the sharing agreements by VAMC, service, and sharing agreement type (FTE-based or per-procedure), and type of monitoring error.

Estimated Savings Related to Negotiation of Medicare-Based Rates

For each per-procedure contract that based its charges on Medicare rates, we referred to the CMS website to determine the applicable Medicare rates. For each procedure charged by the contractor, we calculated the Medicare rate for the work, malpractice, and practice components using the formula and values from the CMS website and then compared the total amount we calculated to the total amount charged for each medical procedure listed in contractor invoices. We determined that the practice component had been charged for all 21 sharing agreements. Table 3 on page 19 shows the amounts that the VAMCs could have saved if their sharing agreements had been negotiated to exclude the practice component from the Medicare-based charges.

Appendix A

Table 2. Overpayments Related to Performance Monitoring By VAMC and Sharing Agreement

	VAMC	Service Description	Sharing Agreement Type	Amount Overpaid	Reason Code	Amount Recov-erable
1	Indianapolis	Neurosurgery	FTE-based	$165,450	A	
2	Indianapolis	Vascular Surgery	FTE-based	$333,030	A	
3	Indianapolis	Orthopedic Surgery	FTE-based	$280,125	A	
4	Indianapolis	Urology	FTE-based	$168,093	A	
5	Miami	Cardiothoracic Surgery	FTE-based	$521,037	A	
6	Miami	Otolaryngology	FTE-based	$272,495	A	
7	Miami	Neurosurgery	FTE-based	$233,380	A	
8	Miami	Gynecologic Surgery	FTE-based	$83,025	A	
9	Miami	Orthopedic Surgery	FTE-based	$266,742	A	
10	Miami	Hand Surgery	Per-procedure	$28,192	A	
11	Minneapolis	Neurosurgery	FTE-based	$59,515	A	
12	Minneapolis	Ophthalmology	FTE-based	$8,461	A	
13	Minneapolis	Ophthalmology	FTE-based	$24,000	A	
14	Minneapolis	Urology	FTE-based	$72,201	A	
15	Minneapolis	Orthopedic Surgery	FTE-based	$29,988	A	
16	Minneapolis	Ophthalmology	Per-procedure	$41,809	B, C	$41,809
17	Omaha	Anesthesiology	FTE-based	$799,821	A	
18	Omaha	Plastic Surgery	Per-procedure	$2,395	B	$2,395
19	Omaha	Orthopedic Surgery	Per-procedure	$2,824	B	$2,824
20	Omaha	General Surgery	Per-procedure	$1,022	B	$1,022
21	Omaha	Neurosurgery	Per-procedure	$2,374	B	$2,374
22	Omaha	Neurosurgery	Per-procedure	$6,090	B	$6,090
23	Omaha	Neurosurgery	Per-procedure	$9,678	B	$9,678
24	Omaha	Neurosurgery	Per-procedure	$6,474	B	$6,474
25	Omaha	Otolaryngology	Per-procedure	$5,028	B	$5,028
26	Omaha	Ophthalmology	Per-procedure	$5,358	B	$5,358
27	Reno	Neurosurgery	Per-procedure	$12,614	B	$12,614
28	San Antonio	Urology	Per-procedure	$557,954	A	
29	Seattle	Anesthesiology	FTE-based	$106,843	A	
30	Seattle	Ophthalmology	FTE-based	$35,455	A	
		Total Overpayments		**$4,141,473**		**$95,666**

Reason Codes:

A - Contracted Service Was Not Received/Needed

B - Errors in Computing Medicare Charges

C - Charges Exceeded Daily Cap

Appendix A

Table 3. Potential Savings Resulting from Excluding the Medicare Part B Practice Component

	VAMC	Service Description	Potential Savings
1	Miami	Hand Surgery	$126,537
2	Miami	Urology	$209,230
3	Miami	Colorectal Surgery	$104,506
4	Minneapolis	Ophthalmology	$27,800
5	Minneapolis	Cardiothoracic Surgery	$90,876
6	Minneapolis	Vascular Surgery	$67,521
7	Omaha	Podiatry	$43,475
8	Omaha	Plastic Surgery	$50,939
9	Omaha	Orthopedic Surgery	$46,345
10	Omaha	Orthopedic Surgery	$109,331
11	Omaha	General Surgery	$2,200
12	Omaha	General Surgery	$4,218
13	Omaha	Neurosurgery	$83,319
14	Omaha	Neurosurgery	$23,727
15	Omaha	Neurosurgery	$32,011
16	Omaha	Neurosurgery	$29,153
17	Omaha	Otolaryngology	$53,991
18	Omaha	Otolaryngology	$63,343
19	Omaha	Ophthalmology	$126,742
20	Reno	Neurosurgery	$33,266
21	Seattle	Orthopedic Surgery	$76,594
		Total Potential Savings	**$1,405,124**

Appendix B

Monetary Benefits in Accordance with IG Act Amendments

Recommendations	Explanation of Benefits	Better Use of Funds	Questioned Costs
1–4	Strengthen controls over clinical sharing agreement performance monitoring.	$47.4 million [2]	
5	Initiate recovery of sharing agreement overpayments identified by this audit.		$95,666
6, 7	Provide contracting officers training and implement oversight mechanisms to ensure that per-procedure sharing agreements exclude the Medicare practice component.	$12.4 million	
	Total	$59.8 million	$95,666

[2]Most of the sharing agreements did not include provisions for reducing payments if less services were provided than anticipated. Therefore, we classified these costs as better use of funds and not questioned costs.

Appendix C

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: SEP 23 2008

From: Under Secretary for Health (10)

Subj: OIG Draft Report, *Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*, Project No.: 2008-00477-R8-0033 (WebCIMS 411947)

To: Assistant Inspector General for Audit (52)

1. I have reviewed the draft report, and I concur with the report findings, recommendations and the monetary benefits estimate. I agree that strengthened controls over sharing agreement monitoring are essential to ensure that the contracted clinical services rendered at VHA facilities are accurately compensated. In fact, VHA's Medical Sharing Office is in the process of establishing a contract to provide clinical pricing services to support Veterans Integrated Service Networks (VISN) staff responsible for developing and monitoring medical sharing contracts. Development of performance monitoring training for Contracting Officer's Technical Representatives (COTRs) that specifically addresses clinical sharing agreements, and training for VISN contracting officers on per-performance sharing agreements with Medicare-based charges, will provide useful instruction and criteria in monitoring clinical sharing agreements.

2. Thank you for the opportunity to review the draft report. Attached is an action plan that outlines measures planned to implement the recommendations. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5) at (202) 461-8470.

Michael J. Kussman

Michael J. Kussman, MD, MS, MACP

Attachments

OIG Draft Report, *Audit of Veterans Health Administration Noncompetitive Clinical Sharing Agreements*

Project No.: 2008-00477-R8-0033

Date of Report: August 18, 2008

Recommendations/Actions	Status	Completion Date

Recommendation 1. We recommend that the Under Secretary for Health ensure that VISNs establish standardized written procedures for monitoring FTE-based and per-procedure clinical service sharing agreements.

Concur

The Medical Sharing Program Office within VHA's Office of Procurement and Logistics will develop standardized written procedures for monitoring FTE-based and per-procedure clinical service sharing agreements. Pending rewrite of the directive a memorandum will be processed outlining these requirements.

In process December 30, 2008

Recommendation 2. We recommend that the Under Secretary for Health establish VISN-level oversight controls to ensure that COTRs are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.

Concur

The Medical Sharing Program Office within VHA's Office of Procurement and Logistics will work with Network Contract Managers to establish VISN level oversight controls to ensure that COTRs are effectively monitoring contractor performance under the terms of the sharing agreement before certifying invoices for payment.

In process March 31, 2009

Recommendation 3. We recommend that the Under Secretary for Health implement procedures to ensure that COTRs verify that Medicare-based sharing agreement charges are accurately calculated prior to certifying contractor invoices.

Concur

The Medical Sharing Office is establishing a contract to provide clinical pricing services that will be available to support all VISN staff responsible for developing and monitoring medical sharing contracts. Part of the clinical pricing services will include validation of Medicare-based rates. The procedures developed for providing quality control monitoring requirements will include a control function for certification of the Medicare rates being used. The contractor hired will be responsible for certifying the Medicare rates are accurate and correctly

applied to the services provided before invoices are certified.

In process October 30, 2009

Recommendation 4. We recommend that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.

Concur

VHA will collaborate with VA's Office of Acquisition and Logistics to develop performance monitoring training for COTRs that specifically addresses clinical sharing agreements.

In process March 31, 2009

Recommendation 5. We recommend that the Under Secretary for Health instruct the VISN contracting officers to initiate recovery of overpayments identified by our audit, as appropriate.

Concur

The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will send a memorandum to field Network Directors instructing them to require the identified VISN Contracting Officers to begin immediate recovery of overpayments via appropriate mechanisms available to them.

In process December 30, 2008

Recommendation 6. We recommend that the Under Secretary for Health coordinate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.

Concur

VHA will collaborate with VA's Office of Acquisition and Logistics to develop training for VISN contracting officers on negotiating per-procedure sharing agreements with Medicare-based charges.

In process March 31, 2009

Recommendation 7. We recommend that the Under Secretary for Health implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.

Concur

The Medical Sharing Program Office within VHA's Office of Procurement and Logistics will work with Network Contract Managers to implement oversight mechanisms to ensure that per-procedure sharing agreements for onsite clinical services exclude the Medicare practice component charges from contract rates, as required by VA policy.

In process March 31, 2009

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	Claire McDonald (206) 220-6651
Acknowledgments	Ron Stucky Sherry Ware Barry Johnson Randy Alley Kevin Day Maria Foisey Matthew Rutter Orlando Velasquez

Appendix E

Report Distribution

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